IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

JEFFREY C. MILLER, Acting Director, Illinois Department of Public Aid,

Appellant,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., on their own behalf and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation, and JANE DOE, on her own behalf and on behalf of all others similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

BRIEF OF APPELLANT MILLER

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INDEX

TABLE OF AUTHORITIES

Cases

Constitution, Statutes and Regulations

Miscellaneous Authorities

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OPINIONS BELOW

The opinion of the District Court on review is reported at 469 F.Supp. 1212 (N.D. Ill. 1979) and is reproduced in the State's Jurisdictional Statement, A21. The prior District Court opinions are unreported. The abstention order of December 21, 1977 is in the Jurisdictional Statement of the United States. 91a; the memorandum opinion may be found at R. 13. The opinion of the United States Court of Appeals for the Seventh

Circuit reviewing the abstention order is reported at 572 F.2d 582 (7th Cir. 1978). The opinion of the District Court on remand is in the Jurisdictional Statement of the United States, 54a. The opinion of the Seventh Circuit on the statutory issues is reported at 596 F.2d 196 (7th Cir. 1979).

JURISDICTION

The Final Judgment and Order of the District Court (Jurisdictional Statement, A43) was entered on April 30, 1979. The State filed an amended Notice of Appeal to this Court on May 8, 1979 (App. 151). The Jurisdictional Statement was filed on July 2, 1979. The jurisdiction of this Court is invoked under 28 U.S.C. § 1252. *International Ladies' Garment Workers' Union* v. *Donnelly Garment Co.*, 304 U.S. 243 (1938); *United States* v. *Raines*, 362 U.S. 17 (1960); and *McLucas* v. *DeChamplain*, 421 U.S. 21 (1975).

QUESTIONS PRESENTED

1. Has the appellate jurisdiction of the Supreme Court under Title 28 U.S.C. § 1252 been properly invoked in this case?

2. Are the provisions of P.A. 80-1091 amending the Illinois Public Aid Code so as to limit public funding of abortions solely to those instances where an abortion is "necessary for the preservation of . . . life" consistent with the rights and obligations of the state under Title XIX of the Social Security Act as amended by the "Hyde Amendment" to the Departments of Labor, and Health, Education and Welfare Appropriation Act?

3. Without regard to the "Hyde Amendment," is Illinois free under Title XIX and its implementing regulations to exclude from the scope of coverage of its non-comprehensive state plan for medical assistance all abortions not "necessary for the preservation of . . . life"?

4. Does the Equal Protection Clause of the Fourteenth Amendment forbid the State of Illinois, through its normal democratic processes, from making a value judgment favoring its interests in fetal life and normal child birth over abortion, and implementing that judgment by the allocation of public funds to indigent, pregnant women seeking abortions only where "necessary for the preservation of . . . life"?

5. Does P.A. 80-1091 violate the Fourteenth Amendment rights of indigent, pregnant women seeking "medically necessary" abortions where the State funds alternative modes of treatment for the complications of pregnancy?

CONSTITUTIONAL AND STATUTORY PROVISIONS

Fifth Amendment, United States Constitution:

No person shall be . . . deprived of life, liberty, or property, without due process of law . . . .

Fourteenth Amendment, United States Constitution:

SEC. 1. . . . No state shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

P.A. 80-1091, ILL. REV. STAT. *ch. 23, §§ 5-5, 6-1, 7-1 (Supp. 1977)*

[This statutory provision is reproduced in full in the Addendum hereto, Add. 1a].

Departments of Labor, and Health, Education and Welfare, Appropriation Acts, for the fiscal years 1977, 1978, 1979 and 1980 (commonly known as the "Hyde Amendments")

[These statutory provisions are reproduced in full in the Addendum hereto, Add. 4a].

STATEMENT OF THE CASE

Jeffrey C. Miller, Acting Director of the Illinois Department of Public Aid and principal defendant in this action, is responsible for the administration of the Illinois Public Aid Code, ILL. REV. STAT. ch. 23, § 1-1 *et seq.* (1977).[1] The Illinois Department of Public Aid is the "single state agency" designated to administer the Illinois state plan for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*[2]

In 1977 the Illinois General Assembly, overriding the veto of Governor James R. Thompson, enacted into law P.A. 80-1091, which amended the scope of the state's medical assistance programs for the indigent by excluding as a covered medical procedure, and prohibiting public funding of, abortions for indigent pregnant women unless in the opinion of a treating physician an abortion is "necessary for the preservation of the life of the woman seeking such treatment." ILL. REV. STAT. ch. 23, §§ 5-5, 6-1, 7-1 (Supp. 1977).

On December 6, 1977, David Zbaraz, M.D. and Martin Motew, M.D., members of the Department of Obstetrics and Gynecology at Michael Reese Hospital in Chicago, Illinois, filed this class action under the Civil Rights Act, 42 U.S.C. § 1983, in the District Court for the Northern District of Illinois, Eastern Division, challenging the validity of P.A. 80-1091 on federal statutory and constitutional grounds. Alleging jurisdiction under 28 U.S.C. § 1331 and 28 U.S.C. § 1343(3), (4), the plaintiffs claimed that the state abortion funding limitation "denies them and their [pregnant] indigent women patients needing medically necessary abortions their rights under the Social Security Act, and the Ninth and Fourteenth Amendments to the United States Constitution." (R.1, Complaint, § 1). Plaintiffs sought declaratory and injunctive relief against defendant's threatened enforcement of P.A. 80-1091 and class certification under FED. R. CIV. P. 23 of a class of all physicians participating in the state's medical assistance programs and who perform "medically necessary" abortions for their indigent women patients (R. 18).

[1] At the time this case was filed, Arthur F. Quern was the Director of the Illinois Department of Public Aid and the principal defendant. In September of 1979, Director Quern resigned from office and was replaced by Jeffrey C. Miller, the current Acting Director.

[2] In addition to the state's Title XIX program, Director Miller also administers two wholly state authorized and funded public assistance programs—the General Assistance Program, ILL. REV. STAT. ch. 23, § 6-1 *et seq.* (1977); and the Aid to the Medically Indigent program, ILL. REV. STAT. ch. 23, § 7-1 *et seq.* (1977).

Jasper F. Williams, M.D. and Eugene F. Diamond, M.D. petitioned the District Court pursuant to FED. R. CIV. P. 24(a)(2) to intervene in the lawsuit as party-defendants in order to protect their own economic interests and for the purpose of representing the interests of unborn children which would be impaired were plaintiffs to prevail (R. 24). The motion for intervention was opposed by the plaintiffs and was taken under advisement by the court.

Because the District Court believed that the "life-preservation" standard utilized in P.A. 80-1091 could be interpreted by Illinois courts in a way that would avoid the federal statutory and constitutional challenges, an abstention order was entered by the District Court on December 21, 1977 in order to give the Illinois courts an opportunity to definitively construe the new legislation in the face of a claim that the statute excluded funding for "medically necessary" abortions as defined by the plaintiffs (R. 13).

Plaintiffs appealed the abstention order to the United States Court of Appeals for the Seventh Circuit. Pending the outcome of the appeal, the Seventh Circuit issued an injunction against enforcement of the Illinois statute and compelled the State to fund all "therapeutic" abortions. Relying on this Court's language in *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973),

the Court of Appeals defined "therapeutic" to mean "medically necessary or medically indicated according to the professional medical judgment of a licensed physician in Illinois, exercised in light of all factors affecting a woman's health." In *Zbaraz* v. *Quern*, 572 F.2d 582 (7th Cir. 1978) ("Zbaraz I") the Seventh Circuit reversed the District Court's abstention order but intimated no view on the merits of the relief plaintiffs were seeking. The Court dissolved its injunction and remanded the case for expeditious consideration of preliminary injunctive relief.

On remand, plaintiffs filed a motion for leave to have Jane Doe joined as a party-plaintiff and for leave to file amended and supplemental pleadings (R. 58, 59). The supplemental pleadings describe Plaintiff Doe as a 38 year old pregnant woman who was examined at Michael Reese Hospital by two physicians, not parties of record, on the staff of the hospital. In support of the supplemental pleadings, Plaintiff Zbaraz filed an affidavit (App. 92) which states that

> 1. . . . I have reviewed the medical records of Jane Doe, a patient at Michael Reese who was recently examined by two other physicians on the staff of the hospital. The records disclose the following:
>
> Jane Doe is 38 years old and has had nine previous pregnancies. She has a history of varicose veins and thrombophlebitis (blood clots) of the left leg. The varicose veins can be, and in her case were, caused by multiple pregnancies: the weight of the uterus on her pelvic veins increased the blood pressure in the veins of her lower extremities; those veins dilated and her circulation was impaired, resulting in thrombophlebitis of her left leg. The varicosities of her lower extremities became so severe that they required partial surgical removal in 1973.
>
> 2. Given this medical history, Jane Doe's varicose veins are almost certain to recur if she continues her pregnancy. Such a recurrence would require a second operative procedure for their removal. Given her medical history, there is also about a 30% risk that her

> thrombophlebitis will recur during the pregnancy in the form of "deep vein" thrombophlebitis (the surface veins of her left leg having previously been partially removed). This condition would impair her circulation and might require prolonged hospitalization with bed rest.
>
> 3. Considering Jane Doe's medical history of varicose veins and thrombophlebitis, particularly against the background of her age and multiple pregnancies, it is my view that an abortion is medically necessary for her, though not necessary to preserve her life.

The District Court by Order of April 25, 1978 granted plaintiffs leave to join Jane Doe as a party plaintiff and permitted the filing of amended pleadings (R. 62). Thereafter the parties, including the movants for intervention as party-defendants, filed cross motions for summary judgment (R. 56, 57, 63).

On May 15, 1978 the District Court issued a memorandum opinion which (1) granted the motion to intervene of Jasper F. Williams, M.D. and Eugene F. Diamond, M.D.; (2) certified two plaintiff classes pursuant to FED. R. CIV. P. 23(b)(2)[3]; (3) denied Defendant Quern's motion to dismiss for want of jurisdiction; and (4) granted plaintiffs' motion for summary judgment based solely on the statutory issues raised in the complaint (R. 64).

The court found that Section 101 of Pub. L. 95-205 (the Hyde Amendment to the Departments of Labor and Health, Education and Welfare Appropriations Act for 1978) was not intended by Congress to alter the substantive requirements of Title XIX with respect to state funding of "medically necessary"

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[3] The classes certified by the District Court consist of (1) all pregnant women eligible for the Illinois Medical assistance programs for whom an abortion is medically necessary but not necessary for the preservation of their lives and who wish such abortion performed, and (2) all Illinois physicians who are certified to obtain reimbursement for necessary medical services rendered to and who perform medically necessary abortions for, persons eligible for medical services under [the "Illinois medical assistance programs"].

abortions.[4] Construing Title XIX to oblige participating states to fund all "medically necessary" services, the District Court concluded that P.A. 80-1091, by denying funds for abortions deemed "medically necessary" in the discretion of attending physicians, was inconsistent with the objectives of the Act, 42 U.S.C. § 1396, the "reasonable standards" requirement of § 1396a(a)(17) and implementing regulations governing the "amount, duration, and scope" of services, 42 C.F.R. § 449.10(a)(5)(i). [later recodified as 42 C.F.R. § 440.230 (c)(1) at 43 Fed. Reg. 57253 (Dec. 7, 1978)].

Upon appeal to the United States Court of Appeals for the Seventh Circuit, that Court again reversed, *Zbaraz* v. *Quern*, 596 F.2d 196 (7th Cir. 1979) (*Zbaraz II*). The Court in *Zbaraz II*, agreeing with the First Circuit's decision in *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979) *cert. denied*, ____ U.S. ____, 99 S.Ct. 2181, 2182 (1979), held that the Hyde Amendment to the Medicaid Act was intended by Congress to

[4] Congress first enacted an abortion funding limitation under the sponsorship of Congressman Henry Hyde (Rep. Ill.) by adding a rider to the Departments of Labor, and Health, Education and Welfare Appropriation Act for 1977, [commonly referred to as the "Hyde Amendment."] which provided that, "None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term." Pub. L. 94-439, Section 209, 90 Stat. 1418, 1434 (Sept. 30, 1976). Congress passed a similar restriction the following year: "[N]one of the funds provided for in this paragraph shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service; or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term where so certified by two physicians." Departments of Labor, and Health, Education and Welfare and Related Agencies, Appropriation Act, 1978, Pub. L. 95-205, Section 101, 91 Stat. 1460 (Dec. 9, 1977). It was the 1978 Appropriation Act amendment which the District Court considered in its decision of May 15, 1978.

amend Title XIX in regard to abortions, and that under the Medicaid Act, as amended, Illinois could limit medicaid funding to the categories of abortions specified in that amendment.[5] Consequently, Illinois was free to deny funding for all "medically necessary" abortions which a physician could not certify as falling under one of the designated Hyde Amendment categories.

The ruling in *Zbaraz II* worked a judicial revision of P.A. 80-1091, by expanding its terms beyond its original "life-preservation" standard to encompass victims of rape and incest and instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term.

By interpreting the Hyde Amendment as a substantive modification of Title XIX and by revising P.A. 80-1091 to conform to the contours of the federal Act, the Court of Appeals concluded that the constitutional considerations, having been altered by its ruling, should now be passed on by the District Court and thus remanded the case with instructions to the court below to consider "whether the Hyde Amendment, by limiting funding for abortions to certain circumstances even if such abortions are medically necessary, violates the Fifth Amendment in view of the facts that no other category of medically necessary care is subject to such constraints and that abortion has been recognized as a fundamental right." 596 F.2d at 202. The Court of Appeals viewed the Fifth Amendment and Fourteenth Amendment issues as substantially identical with both the federal and state statutes rising or falling together as a result of the resolution of the constitutional issues. 596 F.2d at 203 n. 22.

[5] The Court of Appeals noted that Congress had enacted varying forms of the Hyde Amendment for fiscal years 1977, 1978, and 1979. 596 F.2d 196, 199. The 1979 version, Pub. L. 95-480, Section 210, 92 Stat. 1567, 1586 (Oct. 18 1978) was identical to that for 1978 and the Court of Appeals considered the legislative history of these later amendments in resolving the statutory question before it.

On remand, the District Court modified its permanent injunction so as to require the defendant to fund all Hyde Amendment abortions in his enforcement of P.A. 80-1091 (R. 87).

Since the constitutionality of a federal statute had been drawn into question, Judge Kirkland certified this fact to the Attorney General of the United States pursuant to 28 U.S.C. § 2403(a) and directed the Attorney General to notify the court whether the United States intended to seek permission to intervene for presentation of evidence and for argument on the question of the Hyde Amendment's constitutionality (R. 90).

The United States by letter to Judge Kirkland (App. 100) requested leave to formally intervene pursuant to 28 U.S.C. § 2403(a) and the court granted this request by order of March 8, 1979 (R. 94). Thereafter each party submitted to the Court a motion for summary judgment supported by briefs addressing the constitutional issues (R. 98, 106, 107). Due to health reasons, Judge Kirkland recused himself prior to ruling and the case was reassigned to Judge Grady (R. 115).

In a memorandum opinion dated April 29, 1979 Judge Grady held that the Hyde Amendment and P.A. 80-1091 (as modified by court order) were constitutionally infirm as violative of the plaintiffs' right to equal protection of the laws. *Zbaraz* v. *Quern*, 469 F. Supp. 1212 (N.D. Ill. 1979).

Based upon its reading of the affidavits of Drs. Zbaraz, Depp, and Barglow filed in support of Plaintiffs' Motion for Summary Judgment (App. 102, 113, 123), the District Court concluded that the effect of the Hyde Amendment criteria "will be to increase substantially maternal morbidity and mortality among indigent pregnant women." 469 F. Supp. at 1220. Judge Grady therefore held that "the state has [no] legitimate interest in preserving the life of a non-viable fetus at the cost of increased maternal morbidity and mortality among indigent pregnant women." *Id.*

In the Final Judgment order of April 30, 1979 (R. 124), the federal and state abortion funding statutes, as applied prior to fetal viability, were declared to violate plaintiffs' rights to equal protection of the laws as guaranteed by the Fifth and Fourteenth Amendments, respectively. The order enjoined the state defendant from enforcing P.A. 80-1091 as judicially amended, prior to fetal viability, and compelled the funding of all "medically necessary" abortions under the Illinois medical assistance programs.[6]

Motions by Defendant Quern and the intervening defendants for a stay of the final order pending appeal (R. 123, 125) were denied, without reason, by orders of the court (R. 124, 126). Defendant Quern, upon denial of his stay motion, sought an order requiring the United States to reimburse Illinois for all Title XIX "medically necessary" abortions which would be performed under the Final Judgment Order but which did not meet the Hyde Amendment criteria (App. 143). The United States advised the court that, while the reimbursement issue was not ripe since no federal funds had yet been denied the state, it had no intention of reimbursing Illinois for any non-Hyde Amendment abortions which would be performed as a result of Judge Grady's ruling.[7] The state's motion was entered and taken under advisement (R. 124), and it is presently pending before the District Court.

On May 2, 1979 Defendant Quern filed a Notice of Appeal which indicated that he was appealing the order of April 30th directly to the Supreme Court (R. 127). Intervenors Williams

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[6] The Court defined a "medically necessary" abortion as one "necessary for the preservation of the life or the physical or mental health of a women seeking such treatment, in the professional judgment of a licensed physician in Illinois, exercised in light of all factors relevant to her health." *See*, Appendix to the State's Jurisdictional Statement, A 44.

[7] The Final Judgment order grants injunctive relief only against the state defendant with respect to enforcement of P.A. 80-1091.

and Diamond filed a similar Notice of Appeal on the same day (App. 146). Because his original Notice of Appeal failed to specify that the appeal was pursuant to 28 U.S.C. § 1252, Defendant Quern filed an Amended Notice of Appeal with the required specification on May 8, 1979 (R. 130). On May 29, 1979 the United States filed its § 1252 Notice of Appeal from the April 30th Judgment invalidating the Pub. L. 95-480, § 210, 92 Stat. 1586 (1978) (App. 154).

Director Quern and intervenors Williams and Diamond then applied to Mr. Justice Stevens, Circuit Justice for the Seventh Circuit, for a stay of the judgment order pending appeal. In a written opinion, Mr. Justice Stevens denied the applications for a stay despite a recommendation by the Solicitor General on behalf of the United States that the applications be granted. *Williams* v. *Zbaraz*, ____U.S.____, 99 S.Ct. 2095 (1979). Thereafter, the intervenors presented their application for a stay to Mr. Justice Rehnquist who, in turn, submitted it to the entire Court which denied the application without opinion. ____U.S. ____, 99 S.Ct. 2833 (1979).

The Jurisdictional Statements of Defendant Miller and the intervening defendants were filed in the Supreme Court on July 2, 1979, and that of the United States, with leave of court, on September 21, 1979. Plaintiffs, in response, filed a Motion to Vacate in Part, to Dismiss in Part, and to Affirm. They also filed a Conditional Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit. Both documents assert a common rationale for the Court's disposition of the case. The Hyde Amendment, plaintiffs assert, is not now and never has been an issue in this case and thus the Seventh Circuit committed reversible error in finding that Congress intended that Act to substantively modify a state's obligations under Title XIX. Since the mandate of the Court of Appeals, directing the District Court to resolve the constitutionality of the Hyde Amendment was without basis, plaintiffs contend that this Court has no Article III jurisdiction to review Judge Grady's

ruling as to the Hyde Amendment. Plaintiffs urge this Court to vacate that portion of the final order granting relief with respect to the Hyde Amendment and otherwise affirm the ruling below. Plaintiffs contend that 28 U.S.C. § 1252 provides no basis for review of any of the prior rulings of the courts below. If, however, the entire case does come before the Court, plaintiffs urge affirmance of *Zbaraz II*, insofar as it interprets Title XIX, standing alone, to require funding for "medically necessary" abortions, and reversal, to the extent that the Court of Appeals held that the Hyde Amendment operates substantively to amend Title XIX to permit Illinois to deny funding for most "medically necessary" abortions.

On November 26, 1979 the Court granted review of the issues presented in the several Jurisdicitional Statements, postponed consideration of the question of the Court's jurisdiction under Section 1252 until the hearing on the merits, and consolidated the three appeals. No action has been taken to date with respect to plaintiffs' Petition.

Congress, in making appropriations for the Departments of Labor, and Health, Education and Welfare and related agencies for the fiscal year ending September 30, 1980 resolved for the fourth consecutive year to limit the funding of certain categories of abortions. House Joint Resolution 440, signed into law as Pub. L. 96-123, 93 Stat. 923, 926 (Nov. 20, 1979) provides:

> SEC. 109. Notwithstanding any other provision of this joint resolution except section 102, none of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service.

SUMMARY OF THE ARGUMENT

28 U.S.C. § 1252 authorizes an appeal directly to the Supreme Court from the ruling below declaring Pub. L. 95-480, Section 210, 92 Stat. 1586 (commonly known as the "Hyde Amendment" to Title XIX of the Social Security Act) and its Illinois counterpart, P.A. 80-1091, violative of the United States Constitution. While plaintiffs did not directly challenge the validity of the Hyde Amendment, they did assert a right to relief under Title XIX, 42 U.S.C. § 1396 *et seq.* which required the federal court to interpret the intent of Congress in enacting the Hyde Amendment and to relate that intent to the authority of a state to alter its Medicaid state plan to exclude funding of those abortions which, under the Hyde Amendment, no longer qualified for federal reimbursement.

Since the Medicaid program's essential feature is the shared funding concept, plaintiffs' assertion of a statutory entitlement to "medically necessary" abortions, if true, would have the anomalous result of shifting to the states the costs of funding all such abortions, thereby irreparably altering the basic nature of the compact between Illinois and the Federal government in a scheme of co-operative federalism. Thus the issue of the validity of P.A. 80-1091 under Title XIX was inextricably interrelated to the intent of Congress in enacting the Hyde Amendment and the validity of the federal law.

Since the United States intervened in the case as a party-defendant to defend the validity of the Hyde Amendment and the Court ruled the federal act to be constitutionally infirm, the conditions precedent for a direct appeal under 28 U.S.C. § 1252 have been satisfied. *McLucas* v. *DeChamplain*, 421 U.S. 21 (1975).

Under a Section 1252 appeal, the Court may review all prior rulings below, including statutory rulings of the Court of Appeals. *Fusari* v. *Steinberg*, 419 U.S. 379 (1975). A review of the prior statutory rulings is appropriate since they may be

dispositive of the case thereby avoiding unnecessary constitutional adjudication. In addition, an initial analysis of the statutory questions is desirable as this may alter the constitutional considerations, *Zbaraz* v. *Quern*, 596 F.2d 196 (7th Cir. 1979), or narrow the formulation of a rule of Constitutional law. *United States* v. *Raines*, 362 U.S. 17 (1960).

Illinois has observed a long-standing policy of protecting the life of unborn children and of limiting abortion except where necessary for the preservation of the mother's life. The legislative history surrounding the enactment of P.A. 80-1091 which limits state funding of abortions except where necessary for the preservation of the life of an indigent pregnant woman reflects the legislature's concern that fetal life be protected without endangering maternal health. Abortion was seen as a unique medical procedure, seldom medically necessary to preserve maternal life, and ethically objectionable to the taxpayers of the state who do not want their tax dollars subsidizing the termination of unborn children. The people of the State of Illinois are willing to spend more money to encourage normal childbirth than to pay for all "medically necessary" abortions which concedely would cost less.

The concept of "medically necessary" abortions which plaintiffs seek to vindicate is tantamount to abortion on demand. It fails to consider a physician's obligation to *both* of his patients, the mother and the unborn child. It is devoid of the bioethical considerations which the medical profession recognizes are present in any situation involving pregnancy and abortion. It ignores the fact that most complications of pregnancy are readily treatable by alternative forms of treatment without recourse to abortion. The Illinois "life-preservation" standard does not impose upon medicaid physicians a requirement of "predictive certainty" foreign to the medical profession, which would cause "increased maternal morbidity and mortality." If there is a reasonable probability

that the co-existence of pregnancy and diseases complicating pregnancy will materially and significantly shorten the mother's life or that the pregnancy raises the risk of death, a physician may reasonably conclude that the "life-preservation" standard of the statute may be invoked. Illinois does not hold its Medicaid physicians to a standard of care or diagnosis which differs from the standard that the law otherwise holds them to when it subjects their professional activities to judicial scrutiny, namely, the rendering of medical judgments based upon a reasonable medical probability or certainty.

Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (the "Medicaid program") is a scheme of co-operative federalism wherein participating states have wide latitude to determine the amount, duration and scope of medical assistance which eligible individuals are entitled to receive. 42 U.S.C. § 1396a(a)(17). The act does not contain a requirement that states fund all "medically necessary services." *Zbaraz* v. *Quern*, 596 F.2d 196 (7th Cir. 1979). The act does not define the term "medical assistance" and nowhere mentions any particular medical procedure such as abortion. Illinois' state plan of medical assistance is a non-comprehensive plan and reserves to the state the determination of what is "necessary" care.

Neither the terms of Title XIX nor its implementing regulations require Illinois to fund all abortions deemed "medically necessary" by participating physicians. 42 C.F.R. § 440.230 permits Illinois to limit the "amount, duration and scope" of medical assistance in a non-arbitrary fashion. The state's limitation on the funding of "medically necessary" abortions is reasonable because of the uniqueness of the procedure of abortion which involves, unlike other medical procedures, the termination of fetal life. Since Illinois willingly funds alternative modes of treatment for the complications of pregnancy not encompassed within the "life-preservation" standard of P.A. 80-1091, the state's funding limitation is both reasonable and consistent with the objectives of Title XIX.

The Hyde Amendments to the annual appropriation measures for the Departments of Labor and Health, Education and Welfare for the years 1977, 1978, 1979, and 1980 have altered the obligations of states participating under Title XIX with respect to abortion funding. *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979); *Zbaraz* v. *Quern*, 596 F.2d 196 (7th Cir. 1979). While the Courts of Appeals found that the Hyde Amendment worked a substantive modification to a *mandatory* obligation of the states under Title XIX, the better view is that the federal statute altered the states' *discretionary authority* to fund or not fund "medically necessary" abortions. The legislative history of the federal statute provides support for this view.

It may not be fairly argued that the Hyde Amendment did *not* substantively modify prior law. The judicial standard for finding a substantive modification of prior law is readily satisfied. *Tennessee Valley Authority* v. *Hill*, 437 U.S. 153 (1978). The alternative interpretation of the Hyde Amendment as simply an appropriation measure affecting only federal funding of certain categories of abortions is without any support in the debates of Congress. Moreover, to accept this interpretation would lead to the conclusion that the states would have to assume the full financial responsibility for the funding of abortions as part of a scheme of co-operative federalism. This result would alter the basic scheme of the federal-state sharing of expenses and be tantamount to a repeal by implication of the funding provisions of Title XIX. There is no evidence that this is what Congress intended by enacting the Hyde Amendment.

Illinois' abortion funding limitation is consistent with the Fourteenth Amendment's guarantee of due process and equal protection of the laws. There is no fundamental right to an abortion or to a state funded abortion. *Maher* v. *Roe*, 432 U.S. 464 (1977). Welfare is not a fundamental right. *Weinberger* v. *Salfi*, 422 U.S. 749 (1975).

Traditional equal protection analysis requires a determination of the nature of the right involved and whether the statutory classification operates to the disadvantage of some suspect class or impinges upon some fundamental right protected by the Constitution. *San Antonio School District* v. *Rodriquez*, 411 U.S. 1 (1973)

The right to a publicly funded "medically necessary" abortion is not fundamental and is distinct from the right to privacy recognized in *Roe* v. *Wade*, 410 U.S. 113 (1973). As long as a statutory classification does not unduly interfere with a woman's privacy right, that right does not limit the authority of the state to make a value judgment favoring childbirth over abortion and to implement that judgment by the allocation of public funds. *Maher* v. *Roe*, 432 U.S. 464 (1977) The Illinois statute places no obstacles in the pregnant woman's path to a "medically necessary" abortion not necessary to preserve her life. The obstacle is the woman's indigency. The effect of the law is not unduly burdensome on the woman since the state is willing to provide her with alternative forms of medical treatment to protect the woman's interest in her health. The "life-preservation" standard at issue here is essentially the same as the standard upheld by the Court in *Poelker* v. *Doe*, 432 U.S. 519 (1977).

Neither the pregnant woman nor her physician may successfully assert a substantive due process claim based upon the right to privacy found in *Roe* v. *Wade* as a basis for invalidating P.A. 80-1091. In the area of social welfare and economic legislation, the Court has consistently refused to sit as a "super-legislature" to weigh the wisdom of legislation. The statutory funding limitation presents none of the indicia for due process scrutiny for it neither intrudes upon, coerces or criminalizes the exercise of the privacy right. Moreover, when a woman and her physician assert a right to public funds for an abortion, the issue is no longer one of privacy and the

constitutional focus switches to the public domain and to prerogatives of the legislature to set policy for the community as a whole.

P.A. 80-1091 does not create a suspect classification based on wealth and does not fall into any of the traditional indicia of suspect classes. Illinois' policy to refuse to fund all "medically necessary" abortions does not amount to the imposition of a penalty upon poor women who choose to exercise their *Roe* v. *Wade* right to decide to terminate their pregnancy. Illinois does not deny medical assistance benefits to women seeking a "medically necessary" abortion since it willingly funds alternative forms of treatment for the complications of pregnancy. There is no valid reason to believe that enforcement of the "life-preservation" standard will necessarily result in "increased maternal morbidity and mortality" given the availability of alternative modes of treatment and the reasonable interpretation which the state places upon the "life-preservation" standard.

This case does not present a need for the Court to subject the state law to heightened judicial scrutiny or to demand that the state have a compelling interest justifying the statutory classification. P.A. 80-1091 satisfies the traditional standard of equal protection scrutiny, *Dandridge* v. *Williams*, 397 U.S. 471 (1970), by rationally furthering important and legitimate state interests in fetal life, encouragement of childbirth, population growth and demographic concerns, and fiscal autonomy in the allocation of state funds in a manner reflecting the ethical concerns of its citizens for the principle of the sanctity of human life. *Maher* v. *Roe* and *Poelker* v. *Doe* are dispositive of plaintiffs' constitutional challenge to the validity of P.A. 80-1091. The District Court erred in finding that the state's interest in fetal life was outweighted by the interest in maternal health since the statute adequately protects both interests without lessening the principle of the sanctity of human life. The decision of the District Court should be reversed.

ARGUMENT

I.

28 U.S.C. § 1252 CONFERS APPELLATE JURISDICTION UPON THIS COURT TO REVIEW DIRECTLY THE RULING OF THE DISTRICT COURT

A.

28 U.S.C. § 1252 Authorizes An Appeal Directly To The Supreme Court Whenever A Federal Statute Is Declared Unconstitutional And The United States Is A Party.

By Order of November 26, 1979 this Court agreed to review the ruling of the Honorable John F. Grady, United States District Judge, for the Northern District of Illinois, declaring Pub. L. 95-480, Section 210, 92 Stat. 1586 (commonly referred to as the "Hyde Amendment" to Title XIX of the Social Security Act) and its Illinois counterpart, P.A. 80-1091 to be violative of the Fifth and Fourteenth Amendments to the United States Constitution, respectively. This Court postponed consideration of the question of jurisdiction to the hearing on the merits and it is that question which Director Miller initially addresses.

Title 28 U.S.C. § 1252 authorizes a direct appeal from any federal court decision holding an Act of Congress unconstitutional where the United States is a party to the action:

> Any party may appeal to the Supreme Court from an interlocutory or final judgment, decree or order of any court of the United States . . . holding an Act of Congress unconstitutional in any civil action, suit, or proceeding to which the United States or any of its agencies, or any officer or employee thereof, as such officer or employee is a party.

> A party who has received notice of appeal under this section shall take any subsequent appeal or cross appeal to the Supreme Court. All appeals or cross appeals taken to other courts prior to such notice shall be treated as taken directly to the Supreme Court.

Doubts regarding the Court's appellate jurisdiction apparently stem from the fact that on its face plaintiffs' Complaint seeks no relief with respect to the Hyde Amendment and only challenges the validity of P.A. 80-1091. This fact, however, fails to resolve the jurisdictional question against the defendant for it is plain from the claims that were specifically raised in plaintiffs' pleadings that a determination of the validity of the federal law was unavoidable. By asserting a right to relief under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (App. 9, ¶¶ 1, 9-15, 21, 24), plaintiffs tied the fate of their claims to an interpretation by the federal courts of the intent of Congress in legislating an abortion funding limitation in an appropriations measure authorizing funds for Title XIX services.

P.A. 80-1091 cannot be considered in a vacuum. Medicaid is a program of "co-operative federalism" between the states and the federal government.[8] Congress has statutorily defined the rules of the partnership and the United States Department of Health, Education and Welfare will not authorize federal funds for any Title XIX state plan which fails to conform to the mandatory provisions of the Act as interpreted in the implementing regulations promulgated by that agency. 42 U.S.C. § 1396c. The basic agreement of this federal-state partnership is the concept of shared funding of the costs of delivering medical services to the indigent by which each state which chooses to participate is guaranteed to receive federal reimbursement of, at a minimum, fifty percent (50%) of its total authorized expenditures for medical care for Title XIX recipients. *See*, 42 U.S.C. § 1396b(a)(1) and § 1396d(b).

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[8] *See, King* v. *Smith*, 392 U.S. 309, 313, 316 (1968).

Absent this fundamental provision, there would neither be an incentive for state participation nor a scheme of "co-operative federalism."[9]

Since plaintiffs' statutory claim was that Title XIX mandated that Illinois as a condition of receiving federal funds pay for "medically necessary" services, including "medically necessary" abortions, the Seventh Circuit Court of Appeals correctly perceived that to sustain this claim it was necessary first to discern the intent of Congress in refusing to appropriate federal funds for the very medical procedure at issue in the case. Had the Court accepted plaintiffs' Supremacy Clause argument that P.A. 80-1091 was inconsistent with Title XIX (as interpreted without regard to the Hyde Amendment) the anomalous result would have been to shift the full financial responsibility for Title XIX abortion funding to the State of Illinois, thereby irreparably altering the basic nature of the compact between Illinois and the federal government under Title XIX.

While this factor is sufficient to justify the conclusion of the Seventh Circuit that a resolution of the issue of the validity of P.A. 80-1091 under Title XIX was inextricably interrelated with the significance of the Hyde Amendment, there is additional support for defendant's assertion that the jurisdiction of the Court has been properly invoked. The Court should note that the members of the Illinois General Assembly who debated the passage of P.A. 80-1091 were fully aware of, and motivated by, two events which were federal in origin: Congressional enactment of the Hyde Amendment and this Court's decisions in *Beal* v. *Doe*, 432 U.S. 438 (1977), *Maher* v. *Roe*, 432 U.S. 464

[9] That the shared funding provision defines the essential nature of the Medicaid program was noted by Judge Dooling in *McRae* v. *Mathews*, 421 F. Supp. 533, 538 (E.D.N.Y. 1976), *vacated mem., sub nom., Califano* v. *McRae*, 433 U.S. 916 (1977) where he rejected the argument that passage of the 1977 version of the Hyde Amendment left intact the obligation of the state of New York to fund abortions for which it would receive no federal reimbursement under Title XIX.

(1977), and *Poelker* v. *Doe*, 432 U.S. 519 (1977). See, Transcripts of Debate on House Bill 333 [P.A. 80-1091] at App. 42-52, 65-68, and 78-80. Since these decisions negated the notion that state-funded non-therapeutic abortions were a matter of statutory or constitutional entitlement, P.A. 80-1091 may be seen as Illinois's decision to restructure its Medicaid program to comport with Title XIX, as altered by the Hyde-Amendment, especially in view of the fact that Mr. Justice Powell's ruling in *Beal* referred to the federal abortion funding prohibition. *Beal* v. *Doe*, *supra*, 432 U.S. at 447, n.14.

Moreover, plaintiffs themselves raised the issue of Illinois' reliance on the Hyde Amendment before the defendant even had an opportunity to file any pleading in the case. *See*, Memorandum in Support of Motion for Temporary Restraining Order, (R. 17, p. 11). With the Hyde Amendment at issue by the very nature of plaintiffs' claim, the District Court could not avoid addressing the significance of the federal Act in passing on plaintiffs' Title XIX challenge. *See*, Memorandum Opinion and Order of May 15, 1978, (R. 64). Furthermore, when the Seventh Circuit ruled in *Zbaraz II* that Illinois' statute must be judicially expanded to match the dictates of the Hyde Amendment, the destiny of both statutes became irrevocably intertwined. Once the Court of Appeals found that the more restrictive portions of the Illinois statute were not in compliance with Title XIX, then both the Illinois statute *as construed* and the Hyde Amendment became identical. Thus, any resolution of the constitutional issues would pertain equally to either statute.[10] The Court of Appeals ordered the lower court to

[10] Plaintiffs may not fairly contend that an analysis of the federal statute under the Fifth Amendment and the state statute under the Fourteenth Amendment might be different. Although the Fifth Amendment does not include a specific Equal Protection Clause it has been held to incorporate equal protection rights under its Due Process Clause. *Weinberger* v. *Salfi*, 422 U.S. 749, 770 (1975). Therefore, the Court of Appeals was correct in its view that a review of both statutes would be essentially the same. *Zbaraz* v. *Quern*, *supra*, 596 F.2d at 203 n. 32.

consider the constitutional issues as they related to both statues because it correctly perceived the interrelated and inseparable nature of both statutes.

Finally, all the defendants formally took the position that they were entitled to summary judgment pursuant to FED. R. CIV. P. 56 based upon the constitutionality of the Hyde Amendment under the Fifth Amendment to the Constitution (R. 98, 106, 107). Moreover, after the District Court had declared both the federal and state statutes unconstitutional, Defendant Quern filed a motion to require federal reimbursement for all "medically necessary" abortions (App. 143). Thus, the issue of the constitutionality of the Hyde Amendment was expressly at issue in the case in at least three ways. First, it was addressed of necessity by the court below because of the essential relatedness of the state and federal limitations on abortion funding. Second, it arose by virtue of the pleadings filed by the defendants, even if not by the plaintiffs. Finally, the Seventh Circuit's construction of P.A. 80-1091 rendered the state law identical to the federal act.

The District Court, therefore, properly reached the issue of the constitutionality of the Hyde Amendment, and in reaching a decision holding it invalid provided the basis upon which the defendants have invoked the jurisdiction of this Court under Section 1252. Before the District Court even considered the constitutional issues, it certified to the Attorney General of the United States that the constitutionality of an Act of Congress had been drawn into question (R. 90). The United States requested permission to intervene and the District Court issued an order granting the request (R. 94). The District Court subsequently held the Hyde Amendment, an Act of Congress, unconstitutional. The District Court's conclusion that the Hyde Amendment was unconstitutional was the basis for its order directing that the state fund certain "medically necessary" abortions. Section 1252 is "properly invoked when the court below has made [a] determination of unconstitutionality [that] forms the necessary predicate to the grant or denial of

. . . relief." *McLucas* v. *DeChamplain*, 421 U.S. 21, 30 (1975); *United States* v. *Raines*, 362 U.S. 17, 20 (1960). Since the United States became a party to the case and the District Court held an Act of Congress unconstitutional, each of the requirements of Section 1252 have been met and this Court has jurisdiction to review the decision of the District Court.

B.

An Appeal Pursuant To 28 U.S.C. § 1252 Permits The Court To Review The Entire Case Including All Prior Rulings Below.

Plaintiffs have contended that unless the Court grants their Conditional Petition for Writ of Certiorari the statutory ruling of the Seventh Circuit is not susceptible to review by this Court within the confines of a proper Section 1252 appeal.[11] This assertion is erroneous and regardless of whether the Court ultimately reaches the merits of the constitutionality of federal and state abortion funding limitations, it is both appropriate and desirable that the Court first review the Supremacy Clause rulings below.

The authority to review prior statutory rulings in a Section 1252 case which ostensibly seeks review only of a constitutional ruling below is well established. This Court has long held that once jurisdiction is established under Section 1252, the *entire* case is brought before the Court, allowing the Court to consider all issues arising in the case, including non-constitutional ones. *Fusari* v. *Steinberg*, 419 U.S. 379, 387 n. 13 (1975); *United States* v. *Raines, supra*, 362 U.S. at 24 n. 4.

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[11] *See*, Plaintiffs' Conditional Petition for Writ of Certiorari, p. 12-14, n. 13, n. 14; Motion To Vacate In Part, To Dismiss In Part, And To Affirm pp. 25-33.

In the *Fusari* case.[12] neither party appealed from the statutory portion of the lower court's decision. The court found that the statutory issues could be considered even though not specifically presented by any party because it had jurisdiction over the whole case.

The principle under which the Court is deemed to have all issues before it in a case in which an Act of Congress has been declared unconstitutional clearly has its origins in another firmly established rule of this Court—the avoidance of unnecessary constitutional adjudication. One of the most recent expositions of this principle was set forth in *New York City Transit Authority* v. *Beazer,* 440 U.S. 568, 582 (1979):[13]

> If there is one doctrine more deeply rooted than any other in the process of constitutional adjudication, it is that we ought not pass on questions of constitutionality . . . unless such adjudication is unavoidable. *Spector Motor Co.* v. *McLaughlin,* 322 U.S. 101, 105, 65 S.Ct. 152, 154, 89 L.Ed. 101.

Under the operation of the principle, a court is obligated to consider whether the statutory issues might be dispositive before reaching the constitutional question.

Were the Court to accept plaintiffs' argument that the jurisdiction of the Court on appeal does not extend to the entire case and all the rulings below, the Court would be forced in

[12] Although the *Fusari* case was brought under 28 U.S.C. § 1253, the Court stated that in regard to this issue the same principles govern cases brought under both Sections 1252 and 1253. *Fusari* v. *Steinberg, supra,* 419 U.S. at 387 n. 13.

[13] In both the *Beazer* case and *Califano* v. *Yamasaki,* ____ U.S. ____, 99 S.Ct. 2545, 2553 (1979), the courts below either declined to expressly rule on the statutory issues or failed to consider them at all. On review, the Court considered the statutory issues first, and specifically commented on the failure of the court below to do so, stating in the *Beazer* case that "We do not condone this departure from settled federal practice." 440 U.S. at 582.

effect to violate its long standing rule against unnecessary constitutional adjudication. The interrelation of the two principles in a case in which the constitutional issue provides the basis for a direct appeal is perhaps best illustrated in the *Fusari* case cited above.[14] Despite the failure of either party to raise the statutory issue, the Court felt "compelled to re-examine a statutory claim that may be dispositive before considering a difficult constitutional one." *Fusari* v. *Steinberg, supra,* 419 U.S. at 387 n. 13.

Moreover, an initial analysis of the statutory questions is desirable since this may "alter the constitutional considerations," *Zbaraz* v. *Quern,* 596 F.2d 196, 202, and aid the Court in formulating the issues in a manner which gives force to a related principle observed by the Court: "never to formulate a rule of Constitutional law broader than is required by the precise facts to which it is to be applied." *United States* v. *Raines, supra,* 362 U.S. at 21.

Plaintiffs claim, however, that the term "whole case" as used by this Court in direct appeal cases does not include the statutory issues which were before the Court of Appeals.[15] In support of their contention, they rely upon certain decisions of this Court such as *Farmers & Mechanics National Bank* v. *Wilkinson,* 266 U.S. 503 (1925) and *Union Trust Co.* v. *Westhus,* 228 U.S. 519 (1913). In the *Union Trust* case, the constitutional issue arose by way of an amendment to the

[14] Similarly, the parties in the case of *Regents of the University of California* v. *Bakke,* 438 U.S. 265, 281 (1978), which was before the Court on a Petition for Certiorari originally briefed and argued only the constitutional issues. This Court then requested supplementary briefing on the statutory questions and went on to consider the statutory issues in the case before reaching the constitutional ones.

[15] Yet plaintiffs have argued in their Motion to Vacate in Part, To Dismiss In Part, and To Affirm, page 29, that the Court's jurisdiction does extend to "matters which might provide alternative grounds for affirmance of that decision." The statutory issues fit precisely into that category.

pleadings in the lower court after the nonconstitutional issues had already been decided by the circuit court of appeals. The Court specifically stated:

> There can equally be no doubt that if we have power to pass upon the case on this record, our jurisdiction embraces not only the right to decide the alleged constitutional question raised after the mandate of the circuit court of appeals had been filed in the trial court, but also *all other questions arising on the record, including those passed upon by the circuit court of appeals.* 228 U.S. at 522 (emphasis added).

The Court could not have stated in more unequivocal terms that under the long established rule that the entire case comes before it in direct appeal cases involving the constitutionality of a federal statute, it could review the court of appeals decision.

The Court in the *Union Trust* case went on, however, to decide that it had no jurisdiction to review the case at all due to other limits on its jurisdiction to review decisions of courts of appeals. In reaching its decision, the Court considered the two competing principles—that of hearing the entire case and that of limiting its jurisdiction—and decided to follow a strict approach in determining its jurisdiction. At the time the case was decided, the mandatory jurisdiction of the Court in regard to cases brought under the statutory precursor to Section 1252 extended to an extremely broad class of cases.[16] In order to limit its docket and to avoid falling hopelessly behind in its

[16] The *Union Trust* and *Wilkinson* cases were brought to the Court under the Judicial Code of 1891 (Act of Mar. 3, 1891, ch. 517, § 5, 26 Stat. 827) and the Judicial Code of 1911 (Act of Mar. 3, 1911, Pub. L. 61-475, 36 Stat. 1087) respectively. Those statutes provided for direct appeals from the district court to the Supreme Court in several instances. For example, any case involving the construction or application of the Constitution of the United States, in which the constitutionality of any law of the United States was drawn into question or in which the constitution or law of a state was claimed to be in contravention of the Constitution of the United States could be appealed directly from the district court to the Supreme Court.

caseload, the Court traditionally adopted a very strict and narrow interpretation of the various jurisdictional statutes.[17]

While this Court has adhered to a restrictive interpretation of such obligatory jurisdictional statutes as 28 U.S.C. § 1253, *see, for example, Gonzales* v. *Automatic Employees Credit Union,* 419 U.S. 90 (1974), cases brought under Section 1252 have not been subjected to the same strict construction. *McLucas* v. *DeChamplain, supra,* 421 U.S. at 31 (1975). The explanation for this difference may be in the fact that subsequent to the ruling in the earlier cases relied on by plaintiffs the jurisdictional statutes permitting direct appeals were substantially altered in 1925 and again in 1937 when Congress reduced drastically the obligatory jurisdiction of the Court.[18] Section 1252, which by its terms limits the Court's direct appeal jurisdiction to instances wherein both an Act of Congress has been declared unconstitutional and the United States is a party to the action, itself acts to sharply curtail the number of cases on the Court's obligatory docket.[19] Thus, there is no pressing practical need for the Court to apply a strict construction to the statute. More importantly, however, in the *McLucas* case, the Court felt compelled to adopt an exception to the strict approach because "in § 1252 Congress unambiguously mandated an exception to this policy in the narrow circumstances that the section identifies . . ." 421 U.S. at 31. Mr. Justice Powell, speaking for the Court, clearly enunciated that the reasons for the exception were:

[17] The burden on the Court due to the excessive number of cases on its obligatory docket spurred a movement for reform, which was led by Chief Justice Taft. *Report of the Study Group on the Caseload of the Supreme Court* (Federal Judicial Center, 1972), 57 F.R.D. 573, 583.

[18] *See,* Act of Feb. 13, 1925, Pub. L. 64-451, 43 Stat. 938 and Act of Aug. 24, 1937, Pub. L. 75-352, §§ 2, 5, 50 Stat. 752, 753.

[19] It has been reported that "in recent years it has been very rare for district courts to strike down Acts of Congress and thus the direct appeal provision [under Section 1252] is used very little." *Report of the Study Group on the Caseload of the Supreme Court* (Federal Judicial Center, 1972), 57 F.R.D. 573, 602.

> . . . to afford immediate review in this Court in civil actions to which the United States or its officers are parties and thus will be bound by a holding of unconstitutionality. *Id.*

Obviously, Congress contemplated that as short a time period as possible would elapse from the time when a district court held a statute unconstitutional to the time when the Supreme Court would review the case. In addition to explaining why this Court's jurisdiction under Section 1252 is not subject to the limitations on direct appeal to this Court under Section 1253, the *McLucas* Court also emphasized the broad scope of review available under Section 1252, reiterating the principle that it had jurisdiction to review all issues in the case. 421 U.S. at 31.

Since the jurisdictional statute under which the instant appeals have been brought has been substantially changed since the time of the decisions relied upon by plaintiffs, and, since this Court now more liberally construes its jurisdiction under the present statute in contrast to its former strict approach, the decisions in the *Union Trust* and the *Wilkinson* cases cannot be said to represent the current state of the law on the direct appeal jurisdiction of this Court. Similarly, they can no longer, if they ever did, stand as authority for the proposition that this Court has no jurisdiction to review the statutory issues which were before the Seventh Circuit. This Court has consistently held that it must first review statutory issues which might provide alternative grounds in support of a decision before reaching difficult constitutional issues such as the one in this case. If the Court accepts plaintiffs' arguments regarding the scope of the appeal, it will be compelled to disregard the rule and to consider the constitutional issues head on, without the benefit of a clarification of the issues that a resolution of the statutory questions may provide. That would serve to undermine the interrelated purposes of both the principle against unnecessary constitutional adjudication and Section 1252: to permit full and effective review in this Court of all issues in a

case where a federal statute has been invalidated. It is respectfully submitted that this Court should find that it has jurisdiction to review all issues presented, including the statutory questions which were before the Court of Appeals.

II.

FROM *ROE* v. *WADE* TO P.A. 80-1091: ABORTION FUNDING LIMITATIONS AND LEGISLATIVE PURPOSE

Since shortly after its admission into the Union in 1818 to July 19, 1973, Illinois maintained a public policy, patterned after English common and statutory law, of outlawing abortions except when necessary to preserve the life of the mother. ILL. REV. STAT. ch. 38, § 23-1 (1961); REV. STAT., p. 348, div. I, par. 3 (1874); Laws of 1867, p. 89, secs. 1, 2, 3; REV. STAT. p. 158, sec. 46 (1845).

This was the state of the law in Illinois in 1965 when Congress added a new Title XIX to the Social Security Act, Pub. L. 89-97, 79 Stat. 343 (commonly known as the "Medicaid" program) and Illinois opted to participate as a fiscal partner in the new program.

Prior to its repeal in 1973, section 23-1 was construed by the Illinois Supreme Court in *People ex rel. Hanrahan* v. *White*, 52 Ill. 2d 70, 285 N.E.2d 129 (1972). The Court was asked to determine whether section 23-1(b) included "not only physical but psychiatric grounds as an affirmative defense" to felony prosecutions authorized under section 23-1(a). *Id.* at 72, 285 N.E.2d at 130. In an opinion based upon an analysis of legislative history, the Court held that "grounds for a legal therapeutic abortion" in Illinois did not include the concept of mental or psychiatric grounds. *Id.* at 73-74, 285 N.E.2d at 131. In so ruling, the Court reaffirmed that public policy in Illinois has always been to limit "performance of a therapeutic abortion for the preservation of a woman's life due to physical dangers." *Id.* at 73, 285 N.E.2d at 130. The Court expressly noted that

the legislature had contemplated, but rejected, an amendment to section 23-1 to legalize "physical or mental health impairing abortions." This was sufficient for the Court to conclude that there existed a "definite legislative history and rational basis" for excluding psychiatric, and by necessary implication, physical health impairing grounds from consideration as "necessary for the preservation" of the female's life. *Id.* at 75, 285 N.E.2d at 131.

In the wake of this Court's decisions in *Roe* v. *Wade*, 410 U.S. 113 (1973) and *Doe* v. *Bolton*, 410 U.S. 179 (1973), the Illinois Legislature enacted P.A. 78-225, effective July 19, 1973 ILL. REV. STAT. ch. 38, § 81-11 *et seq.*). The new law was intended to implement the ruling in *Roe* v. *Wade* that the Constitution was a bar to the imposition of criminal sanctions and other access-barring requirements for abortions. It was also designed to take cognizance of the competing interests inherent in any abortion decision, including the woman's qualified right to privacy, the state's interest in maternal health and childbirth, and the protection to be accorded potential human life, by regulating the conditions under, and purposes for which, abortions may be performed, § 81-14.

In 1975, the Illinois legislature enacted a new criminal abortion act, P.A. 79-1126, ILL. REV. STAT. ch. 38, § 81-21 *et seq.* (Supp. 1976) which imposed, *inter alia*, spousal and parental consent requirements as conditions to the performance of any legal abortion. In a preface to the Act, the Illinois General Assembly declared its avowed intention in enacting the measure and set forth a clear statement of the policy of the state respecting fetal life:

§ 81-21. *Legislative Intention*

> It is the intention of the General Assembly of the State of Illinois to reasonably regulate abortion in conformance with the decisions of the United States Supreme Court of January 22, 1973. Without in any way restricting the right of privacy of a woman or the right of a woman to an abortion under those decisions, the General Assembly of the State of Illinois do solemnly declare and find in reaffirmation of the long-standing policy of this State, that the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child's right to life and is entitled to the right to life from conception under the laws and the Constitution of this State. Further, the General Assembly finds and declares that longstanding policy of this State to protect the right to life of the unborn child from conception by prohibiting abortion unless necessary to preserve the life of the mother is impermissible only because of the decisions of the United States Supreme Court and that, therefore, if those decisions of the United States Supreme Court are ever reversed or modified or the United States Constitution is amended to allow protection of the unborn then the former policy of this State to prohibit abortions unless necessary for the preservation of the mother's life shall be reinstated.

Although several provisions of the 1975 Act were struck down as unconstitutional, *Wynn* v. *Scott*, 449 F. Supp. 1302 (N.D. Ill. 1978), *appeal dismissed*, 439 U.S. 8 (1978), *aff'd sub nom.*, *Wynn* v. *Carey*, 599 F.2d 193 (7th Cir. 1979), § 81-21 was left unaffected and is still a statement of the policy of the state of Illinois respecting the value it assigns to fetal life.[20]

While the *Wynn* case was pending, this Court issued its trilogy of decisions dealing with the issue of state funding of abortions for indigent woman under medical assistance programs for the poor. *Beal* v. *Doe*, 432 U.S. 438 (1977); *Maher* v. *Roe*, 432 U.S. 464 (1977); and *Poelker* v. *Doe*, 432 U.S. 519 (1977).

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[20] The Illinois General Assembly recently enacted legislation overriding Illinois case law precluding institution of a cause of action for wrongful death of a fetus unless the fetus was viable at the time of injury. *Green* v. *Smith*, 71 Ill.2d 501, 377 N.E.2d 37 (1978). P.A. 81-946, amending ILL.REV.STAT. ch. 70, adds a new paragraph 2.2 which now provides a cause of action for the wrongful death of a non-viable fetus. *See*, 6 ILL. LEGISL. SERV. 2295 (1979)

Against the background of these decisions as well as in response to Congressional initiatives to limit abortion funding for eligible recipients of medical assistance under Title XIX of the Social Security Act, Pub. L. 94-439, Section 209, 90 Stat. 1418 [the original Hyde Amendment], the Illinois General Assembly took up the debate of House Bill 333, a proposed amendment to Articles V, VI and VII of the Illinois Public Aid Code. ILL. REV. STAT. ch. 23, § 1-1 *et seq.* (Supp. 1977), designed to limit the expenditure of state funds for the performance of any abortion under the Public Aid Code except where "necessary for the preservation of . . . life."

The debates on House Bill 333 (reproduced in full in the separately-bound Joint Appendix, at 42-88) demonstrate the deeply-felt and diverse opinions of the elected representatives of the people of the state concerning affirmative state involvement in, and subsidization of, the performance of abortions in a manner contrary to the State's avowed public policy to protect fetal life.

The following excerpts from the debates illustrate that the supporters of House Bill 333 intended to discourage the unnecessary destruction of fetal life by the withdrawal of state subsidization of non-"life preserving" abortions.[21] Abortion was seen as a unique procedure, rarely necessary on purely physical, life-threatening grounds. Still, it was acknowledged that the final arbiter of the circumstances justifying an abortion "necessary to preserve . . . life" was without question the physician, and not the legislature:

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[21] The members of the General Assembly were debating over the enactment of a "life-preservation" standard. However, different terms were mentioned, depending upon the speaker, for those abortions which were to be funded and which were not to be funded. For example, some legislators used the "therapeutic/non-therapeutic" distinction; others referred to "medically necessary/non-medically necessary" abortions. It is clear from the debates as a whole that reference to "medically necessary" abortions evidenced no intent to fund "medically necessary" abortions as defined by the plaintiffs or the district court, i.e., the *Doe* v. *Bolton* definition. *See* Part III, *infra*.

Representative Leinenweber:

> " . . . [T]he issue is, 'as a matter of public policy of the State of Illinois . . . to pay for abortions that are not medically necessary'. Conceding that . . . the woman's right to privacy is broad enough to include the decision whether to abort. It does not follow that the taxpayers must pay to enable her to fulfill this right. We have many rights guaranteed under the Constitution . . . The State, through its exercise of public policy, decides what right it should fund. . . . The state currently makes no pretense of paying for any and all procedures. . . . There are millions of Illinois taxpayers who believe deeply that nontherapeutic abortions are morally objectionable. These feelings are to be recognized in the public policy of this state . . . "
>
> Illinois House of Representatives, Transcript of Debate on House Bill 333 (May 4, 1977), App. 42, 43.

Representative Bradley:

> " . . . [N]owhere in the Supreme Court's 1973 abortion decision did that majority . . . assert that the right to be free from legal restraints in deciding on . . . and obtaining an abortion, carried with it a duty on the part of the state to pay for the abortion when a pregnant women could not afford one. The expressed will of Congress . . . in the so-called Hyde Amendment . . . that the Federal Government . . . is not to pay for abortions . . . with tax moneys . . . Also, Ladies and Gentlemen of the House, pregnancy is not an illness. An abortion is not just another medical procedure. It is an elective surgery undertaken to relieve stresses which are nearly always social, economic or psychological. Seldom physical to the point of threatening a pregnant woman's life. . . . "
>
> Illinois House of Representatives, Transcript of Debate on House Bill 333 (May 4, 1977), App. 43, 44.

Senator Lemke:

> "If the . . . if the medical personnel at that hospital, of any hospital, determines that this is a . . . that she is in need of a therapeutic abortion, which is a medical determination

and is not my determination, she can have it. . . ."

Illinois Senate, Transcript of Debate on House Bill 333 (June 27, 1977), App. 60.

Representative Duester:

"Very briefly, Ladies and Gentlemen of the House, the question is not here anything to do with individual rights. This legislation does not grant, expand or limit or take away anybody's individual rights. What this legislation does is simply establish the public policy that the people expect to establish in the State of Illinois with respect to the attitude toward life and toward the attitude of what some of us don't like to refer to by what it really is is the killing of unborn children. We are not taking away the Constitutional Rights that have been recognized by the Supreme Court. An individual person anywhere in the State of Illinois can choose to terminate a pregnancy or have that child in the womb killed. What we are doing is saying, 'We're not going to promote it, we're not going to subsidize it, we're not going to reach into the pockets of the taxpayers of Illinois and force them to pay for something that they think is wrong and they think that's something that should be discouraged as a matter of public policy.' The rights remain, what we're doing here is not subsidizing and promoting that practice."

Illinois House of Representatives, Transcript of Debate on House Bill 333 (November 3, 1977), App. 81.

As the legislators frequently spoke of the decision of this Court in *Maher* v. *Roe* and noted the passage of the Hyde Amendment, it is difficult to avoid the conclusion that the Illinois General Assembly viewed those federal developments as essentially altering the obligations of the State of Illinois under its Title XIX program and justifying amendments to the Illinois Public Aid Code paralleling those federal initiatives.

With this historical perspective of state policy and legislative purpose in mind, we turn to a discussion of the concept of "medical necessity" as it relates to pregnancy and abortion in the practice of medicine.

III.

ABORTION FUNDING LIMITATIONS AND THE PRACTICE OF MEDICINE: BIOETHICAL CONSIDERATION, THE CONCEPT OF "MEDICAL NECESSITY", AND MEDICAL ALTERNATIVES TO ABORTION.

[Abortion] involves the most basic and volatile principles about which men can differ: life, death, liberty, privacy, our traditions, our ideals, our moral values.

Byrn v. *New York City Health & Hospital Corp.*, 38 App. Div. 2d 316, 324, 329 N.Y.S. 2d 722, 729, *aff'd*, 31 N.Y. 2d 194, 286 N.E.2d 887, 335 N.Y.S. 2d 390 (1972)

The phrase "between a woman and her physician" is an empty one since the physician is only the instrument of her decision, and has no special knowledge of the moral dilemma or the ethical agony involved in the decision. Furthermore, there are seldom any purely medical indications for abortion.

B. NATHANSON, ABORTING AMERICA 166 (1979), originally at 291 *New England Journal of Medicine* 1189, 1190 (November 28, 1974)

Judge Grady's decision below relied heavily and uncritically upon the affidavits of certain physicians. These affidavits discuss the alleged effect of P.A. 80-1091 and the Hyde Amendment standards on the physicians' professional medical training and judgment respecting the complications of pregnancy and abortion. It is not so much what these physicians say regarding the possible complications of pregnancy and statistics on morbidity and mortality. It is, rather, what they fail to say about the competence of the medical profession to successfully live up to their obligation to treat *both* of their patients, the fetus as well as the mother, in accordance with normal standards of care the law holds them to whenever it reviews the reasonableness of their professional activities. Judge Robinson, speaking for the Court of Appeals for the District of Columbia

in a medical malpractice case involving the failure of a physician to reasonably inform an ailing patient as to the treatment alternatives available and the risks incidental to them, succinctly stated what duty of care the law imposes upon physicians:

> '[T]he yard stick is that degree of care which a reasonably prudent person would have exercised under the same or similar circumstances.' 'Beyond this' . . . 'the law requires those engaging in activities requiring unique knowledge and ability to give a performance commensurate with the undertaking.' Thus physicians treating the sick must perform at higher levels than non-physicians in order to meet the reasonable care standard in its special application to physicians—'that degree of care and skill ordinarily exercised by the profession in [the physician's] own or similar localities.' *Canterbury* v. *Spence*, 464 F.2d 772, 784 (D.C. Cir. 1972) (citations omitted).

Despite this long-standing standard of care to which the law holds physicians, and which as applied to the professional evaluation of medical risks translates as the rendering of professional judgment based upon a "reasonable" medical certainty, Oren Richard Depp, III, M.D., and other physicians insist that P.A. 80-1091 and the Hyde Amendment standards impose upon them a standard of "predictive certainty" and requires "physicians to make absolute judgments which they have been taught they cannot make." Affidavit of Depp, App. 109, ¶ 15. Confident in this medicolegal opinion, Dr. Depp asserts, and the District Court found, that the effect of the Hyde Amendment standards "will be to increase substantially maternal morbidity and mortality among indigent pregnant women." App. 111, ¶ 18; *Zbaraz* v. *Quern*, 469 F.Supp. 1212, 1219-1220.

Plaintiffs' ideological manipulation of medical concepts and legal requirements is not supported by standard medical texts. These texts carefully distinguish between ethical, legal

and purely medical considerations attending the treatment of pregnancy-related medical problems and the performance of abortions and do not attempt to impose a simplistic reductionism to statistical data upon complex bioethical questions. S. ROMNEY et al., GYNECOLOGY AND OBSTETRICS—THE HEALTH CARE OF WOMEN 34 (1975) [hereinafter cited as ROMNEY].

The aim of obstetrics "is that every pregnancy be wanted and culminate in a healthy mother and a healthy baby." WILLIAMS, OBSTETRICS 2 (15th Ed. 1976) [Hereinafter cited as WILLIAMS]. Pregnancy *per se* is not a disease. The classic definition of disease is that it is "a condition which, if not combatted, leads to further degeneration and death." ROMNEY, 34. Plaintiffs' notion of disease "is based more directly on statistical predictions of mortality and morbidity," *Id.* at 35, "even in the absence of presenting complaints by patients." *Id.* "Thus, the question [posed by the affidavits is] whether society decides that services should be rendered by 'health care' personnel on some ground other than the classical definition of 'disease' ". *Id.*

Medical science recognizes that with respect to abortion there is a considerable amount of controversy and uncertainty, especially regarding the ethical obligations of a treating physician who by definition has *two* patients:

> "The notion that prior to 12 or 13 weeks abortion is safer than childbirth in terms of maternal mortality statistics is a questionable means of assessing the 'value' of fetal life, since it assigns a zero value to the child. In other words, it is methodologically questionable whether the value of a biological entity can be assessed by an analysis of the safety of a technical procedure. Yet others would assign little or no value to a fetus or a child at all unless it was capable of certain functions such as thought, interpersonal relationships, the giving and receiving of love, or some other putative criterion of humanity. Similar debates and forms of argumentation occur about the 'quality of

life' or the nature of 'meaningful life' at its end as at its beginning. In brief, the debate is between biological and relational definitions of life.

Quite separate from these debates is the question of how one is to act when one does not know the answers to the questions under discussion. Who makes the final decisions? Here, separate ethical issues are raised. When in doubt, how should one act: presumptively in favor of life for the fetus? Presumptively in favor of maternal (and/or paternal) decision making? In favor of physician decision making? Suffice it to say that expertise in ethical decision making is not based on what are commonly asserted to be professional insights but rather on value assessments." ROMNEY, 37.

Plaintiff Jane Doe, according to Dr. Zbaraz, presented a "history" of varicose veins, as distinguished from presently existing varicosities. (App. 92) The varices of pregnancy are not a disease "specific to pregnancy", ROMNEY, 713, but are rather a disease "complicating pregnancy", ROMNEY, 794-795. Treatment of varicosities does not include abortion and "is generally limited to periodic rest with elevation of the legs, or elastic stockings, or both. Surgical correction of the condition during pregnancy is usually not advised." WILLIAMS, 260-261.

Based upon a prior history of "thrombophlebitis",[22] Dr. Zbaraz concluded that (1) her varices "were almost certain to recur"[23] and (2) there existed "about a 30% risk that her thrombophlebitis will recur during the pregnancy in the form of 'deep vein' thrombophlebitis." App. 92. While acknowledging in one breath that there was an available alternative mode of

[22] Thus, Plaintiff Doe did not have *present* symptoms of the disease, only a prior history.

[23] It is ironic that physicians who rail against the "predictive certainty" imposed upon them by P.A. 80-1091 can make nearly absolute medical judgments about what will occur in the future for a patient based upon abstract statistical data. Physicians treat patients on a case by case basis, not abstract populations based wholly on statistical predictions.

treatment, namely "bed rest", Dr. Zbaraz avers that in his medical judgment "an abortion is necessary for her, though not necessary to preserve her life." *Id.* What Dr. Zbaraz failed to state is that superficial "thrombophlebitis" rarely, if ever, necessitates an abortion, and that the condition is adequately managed by the administration of "heparin" a medication which prevents the formation of blood clots and is routinely and safely administered during pregnancy. WILLIAMS, 770, 772.

Moreover, the Court should take note of the fact that Dr. Zbaraz carefully did *not* state that Plaintiff Doe, upon examination, presented symptons of "deep vein" thrombophlebitis, which is a disease that carries a serious risk of pulmonary embolism, a potentially fatal complication. Nor did he mention that absent the occurrence of a pulmonary embolism that "deep vein" thrombophlebitis is treatable with antibiotics (if accompanied by inflammation), analgesia, elastic stockings and heparin. WILLIAMS, 771. And Dr. Zbaraz fails to explain why he could not certify an actual occurrence of "deep vein" thrombophlebitis as a condition warranting an abortion "necessary for the preservation of . . . life" given the serious risk of a pulmonary embolism that accompanies that disease when it in fact strikes.

There is nothing in the record in this case that indicates that the State of Illinois expects Medicaid physicians to conform to some standard of medical practice or standard of care which differs from their training or imposes upon them, through the enforcement of P.A. 80-1091, concepts foreign to their profession. All Illinois expects is that a physician, who believes that an abortion for a patient is "necessary for the preservation of [her] life", certify that fact based upon a "reasonable medical certainty." This is the standard to which physicians are routinely held by the law when their professional activities become subject to legal scrutiny. *See*, Affidavit of Kenneth Wilson, (App. 136), disclaiming any suggestion that the state agency

second-guesses the certifications of physicians that an abortion falls under the ambit of P.A. 80-1091, absent some other indication for review, such as evidence of fraud.

This is the same position that the Department of Health, Education and Welfare took when it promulgated regulations to the Hyde Amendment. 43 Fed. Reg. 31876 (July 21, 1978). The comments of the federal agency make clear that, within the scope of abortions which will be funded, it is the physician who is the final arbiter of the "life preserving" standard:

> . . . [A]n analysis of the legislative history . . . coupled with the history of the Department's administration of the abortion limitation in the 1977 HEW appropriations act . . . dictate that these decisions must be left to physicians on an individual basis. It would be inappropriate . . . to specify the factors that physicians should take into account in making the determinations, or to spell out in greater detail the meaning of the terms . . . the Department must rely on these physicians to utilize their best medical judgment. 43 Fed. Reg. 31876 (July 21, 1978).

Against this analysis, the Court should examine the concept of "medical necessity" which Plaintiffs have taken from *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973) and inappropriately inserted into the abortion funding issue. A concept of "medical necessity" which permits a physician in making professional judgments to take into account "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient" is, defendant respectfully submits, antithetical to the intent of Congress that states participating in the Medicaid program have wide latitude in establishing "reasonable standards . . . for determining eligibility for and the extent of medical assistance" under its state plan. 42 U.S.C. § 1396a(a)(17). The objectives of physicians like Dr. Depp appear to transcend the purely medical realm when he asserts that "the percentage of abortions any physician would deem 'medically necessary' is likely to fall between 20% and 50% of representative cases in which the pregnant woman

wants an abortion." Depp affidavit, ¶ 11, App. 107. *See also,* Affidavit of Peter Barglow, M.D., ¶ 10, App. 118 ("I would estimate that approximately 25% of a group of low income, pregnant women . . . have a psychiatric need for abortion"); ¶ 11, App. 118 ("I would estimate that approximately 35% of a group of low income, pregnant adolescents would, after examination, be judged to have a psychiatric need for an abortion.").[24]

Not every physician who specializes in obstetrics and gynecology is prepared, under the guise of "medical necessity," to ignore so readily as plaintiffs his ethical obligations to his *other* patient or be so reticent about clinical intervention for the purpose of treating the complications of pregnancy without recourse to abortion except where palpably necessary. One physician, whose bioethical perceptions have been transformed as the result of his deep personal involvement in the effort to legalize abortion and provide abortion services, makes a well-reasoned plea to his colleagues for the acceptance of a medically sophisticated and flexible life-preservation standard for the performance of abortions. B. NATHANSON, ABORTING AMERICA 242-247 (1979), reproduced in the addendum hereto at Add. 79a-84a. [hereinafter cited as NATHANSON].

"The list of indications [which satisfy Dr. Nathanson's life-preservation standard of necessity] *cannot be etched in stone;* it varies by medical knowledge." NATHANSON, 243 (Add. 79a). "There must . . . be a reasonable probability that the coexistence of pregnancy [and diseases complicating pregnancy] will materially and significantly shorten the mother's life" or

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[24] In debating the 1978 version of the Hyde Amendment the Senate proposed to limit abortion funding except where "medically necessary." 123 Cong. Rec. S 11051 (daily ed. June 29, 1977). Opponents rejected this language as being tantamount to abortion on demand. 123 Cong. Rec. S 11054 (Sen. Domenici) (daily ed. June 29, 1979); 123 Cong. Rec. S 13671 (Sen. Schweiker) (daily ed. Aug. 4, 1977).

that "pregnancy raises the risk of imminent death." NATHANSON, 244 (Add. 81a). Dr. Nathanson rejects the invocation of "medical indications" without more as sufficient justification for an abortion since such an approach is so inherently elastic as to encompass all *elective* abortions within its ambit. At the heart of Dr. Nathanson's argument there is a respect for the sanctity of life which leads him as a medical professional to believe that the taking of fetal life is not medically justified except where reasonably and palpably necessary to preserve the mother's life.

Through its normal democratic processes, Illinois has reached the same conclusion. By enacting P.A. 80-1091, the State requires Medicaid physicians, as a condition of receiving public funds, to take reasonable measures to treat the complications of pregnancy without recourse to abortion except where the physician can certify, to a reasonable medical certainty, that aborting the fetus is palpably necessary to preserve maternal life from a risk materially posed by the coexistence of the pregnancy and disease complicating pregnancy. This is a fair interpretation of the state law based upon the legislative history of P.A. 80-1091, the review and reimbursement policies of the state agency charged with enforcing the act, and the legal standard of care and certainty to which all physicians are held by the law when their activities are subject to judicial scrutiny.

The question then posed is whether plaintiffs have a claim of statutory entitlement to all "medically necessary" abortions under Title XIX of the Social Security Act without regard to the bioethical consideration underlying P.A. 80-1091, the availability of state funds for alternative modes of treatment and the limitations placed upon state discretion by congressional enactment of the Hyde Amendment.

IV.

TITLE XIX OF THE SOCIAL SECURITY ACT DOES NOT ENTITLE INDIGENT WOMEN OR THEIR PHYSICIANS PUBLIC FUNDING FOR ALL ABORTIONS DEEMED "MEDICALLY NECESSARY"

The Seventh Circuit Court of Appeals in *Zbaraz II*, adopting the reasoning of the First Circuit in *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979), *cert. denied.*, ____ U.S. ____, 99 S.Ct. 2181 (1979), concluded that without regard to the Hyde Amendment, Title XIX of the Social Security Act prohibited states from singling out "medically necessary" abortions as a procedure which the states could refuse to fund except in narrow circumstances. Although both courts went on to hold that the Hyde Amendment was a substantive modification of Title XIX and relieved participating states of the obligation to fund "medically necessary" abortions falling outside the Hyde Amendment categories, Defendant Miller respectfully suggests that these courts erred in their reading of basic Title XIX requirements and their treatment of abortion as comparable to other medical and surgical procedures. Defendant believes that a review of the express terms, implementing regulations and legislative history of the federal statute will demonstrate that without regard to the passage of the Hyde Amendment, States are free to reasonably limit the scope of their Title XIX state plans and exclude care and services which medical providers might imagine to be necessary. Furthermore, since only the procedure of abortion involves the termination of potential human life, placing restrictions on the funding of this unique procedure is a rational means by which a state can protect its interest in fetal life.

A.

Title XIX Does Not Require State Funding Of All "Medically Necessary" Procedures.

This case poses, as a threshold matter, the "serious statutory questions" left unanswered in *Beal* v. *Doe*, 432 U.S. 438 (1977): whether a state Medicaid plan which excludes "necessary" medical treatment from its coverage is consistent with the express terms of Title XIX. As recognized by Mr. Justice Powell in *Beal* the "starting point in every case involving construction of a statute is the language itself," *Beal* v. *Doe*, *Id.*, at 444.

Defendant Miller does not interpret Title XIX as imposing upon Illinois an obligation to fund all conceivable health care or medical services which a medical provider deems to be "medically necessary" or "medically indicated". Medicaid is not a welfare program for providers. Within broad federal guidelines, Medicaid is a state-structured, non-comprehensive program for providing medical services to the indigent with the state determining the amount, duration and scope of the services and care to be provided.[25]

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[25] In 1965, Congress added a new Title XIX to the Social Security Act, Grants to States for Medical Assistance Programs, Pub. L. No. 89-97, 79 Stat. 343 (1965) (Codified at 42 U.S.C. §§ 1396 *et seq.* (1976) and commonly called the "Medicaid" program). Title XIX was intended by Congress to improve and extend the 1960 Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons. S. Rep. No. 404 to Pub. L. 89-97, 1965 U.S. CODE CONG. & AD. NEWS, 1950.

The legislative history of the Act discloses that Congress was cognizant that the program it was establishing was less than comprehensive and that federal financial participation in this new, joint federal/state program was only intended at the beginning to "assure a consistent statewide program at a reasonable level of adequacy." *Id.* at 2015. Congress believed that within ten (10) years, i.e., by 1975, participating states would then be in a position to make substantial "efforts toward broadening the scope of care and services made

(Footnote continued on next page.)

This program of "co-operative federalism," described briefly in Part I, *supra*, imposes certain mandatory requirements upon states such as Illinois, which have elected to participate. As a prerequisite to federal funding under the Act, a state Medicaid plan must provide financial assistance in five general categories of medical services.[26] 42 U.S.C. §§ 1396a(a)(13)

(Footnote continued from preceding page.)

available under the plan," *Id.*, at 2025, and to that end, Congress included a statutory provision limiting federal financial participation to any state failing to provide needy persons comprehensive care by 1975. *See*, Grants to States for Medical Assistance Programs, Pub.L. No. 89-97, § 1903(e), 79 Stat. 349 (1965) (codified as 42 U.S.C. § 1396b(e)).

Arguably, under a comprehensive Medicaid program, participating states such as Illinois would have little discretion or leeway to define standards of medical need or to refuse to fund any conceivable medical procedure so long as the welfare patient's physician deemed the care medically necessary and federal funding was available for the care. However, whatever Congress intended by the inclusion of § 1396b(e) in the 1965 statute, its concept of what the Medicaid program should be was altered in 1972 when it repealed § 1396b(e) *in toto* by the passage of Act of Oct. 30, 1972, Pub. L. 92-603, § 203, 86 Stat. 1410. To date, no subsequent amendments of Title XIX have contemplated a return to the goal of comprehensive care. What remains of the original intent, therefore, is delivery of "adequate" care under a federal/state scheme wherein individual states have a great deal of discretion and leeway in determining the manner and extent to which they will provide medical assistance to needy persons.

In §§ 278(a)(21) and 299E(b) of the 1972 Amendments, Congress added a clause mandating the provision of "family planning services and supplies." 42 U.S.C. § 1396d(a)(4)(C). Congress could have taken this opportunity to require states to fund all therapeutic abortions but it did not. As noted by the Court in *Beal* v. *Doe*, 432 U.S. 438, 447 n. 10, "The failure to exclude abortions from coverage [in § 1396d(a)(4)(C)] indicates only that Congress intended to allow such coverage, not that such coverage is mandatory."

[26] The five general categories are: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing facility services, periodic screening and diagnosis of children, and family planning services; and (5) physician's services.

(B) and 1396d(a)(1)-(5). As to these five categories of services, all that is required is that the state plan include "reasonable standards . . . for determining eligibility for and the extent of medical assistance . . . consistent with the objectives of [Title XIX]." 42 U.S.C. § 1396a(a)(17).

Medical assistance, as defined in 42 U.S.C. § 1396d(a), must be provided to all eligible individuals. 42 U.S.C. § 1396a(a)(8). Illinois extends medical assistance to both the categorically needy, 42 U.S.C. § 1396a(a)(10)(A), a mandatory requirement, and the medically needy, 42 U.S.C. § 1396a(a)(10)(C), an optional requirement. *See, Beal* v. *Doe, supra,* 432 U.S. at 440 n. 1.

Beyond these minimal state plan requirements, the States electing to participate have wide latitude to determine the amount, duration and scope of medical assistance which eligible individuals are entitled to receive: "[N]othing in the statute suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care." *Id.,* at 444.

Congress expressly reposed substantial discretion in participating States in 42 U.S.C. § 1396 which provides, in part:

> § 1396. *Authorization of appropriations*
>
> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . . there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter.

Contrary to the assertions of the plaintiffs below, the language of § 1396 does not evidence an intent by Congress to mandate state funding of all "necessary medical services." Neither the First Circuit in *Preterm, Inc.* v. *Dukakis, supra,* 591 F.2d at 124,

nor the Seventh Circuit in *Zbaraz II, supra,* 596 F.2d at 198-199, accepted the argument that the term "necessary medical services" was intended to qualify the term "medical assistance." Rather, the language which plaintiffs have seized upon, was meant to identify those individuals for whose benefit federal funds are to be appropriated. *Roe* v. *Norton,* 522 F.2d 928, 933 (2d Cir. 1975).

The term "medical assistance" is defined in 42 U.S.C. § 1396d(a) to mean payment "of part or all of the cost" of the services which a state incorporates in its state plan. § 1396d(a) nowhere mentions "necessary medical services," and authorization by Congress for states to pay "part" of the cost of, for example, physician's services suggests strongly that medical providers were not intended to be the final arbiters of what a state plan may or may not include.[27]

Additional evidence of state discretion is reflected in § 1396a(a)(10) which requires comparable treatment among categorically and medically needy recipients. § 1396a(a)(10) provides, *inter alia,*

> (A) for making *medical assistance* available to [the categorically needy] . . . [which] . . .
>
> (B) . . . (i) shall not be less in *amount, duration, or scope* than the medical assistance made available to [the medically needy] . . . (emphasis added)

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[27] Even if the Act contained a requirement that States provide "medically necessary services," the term eludes precise definition by taking on different shades of meaning depending upon the context referred to, such as, the meaning intended by Congress, by individual participating states, by the medical community, or the meaning imparted by constitutional analysis over a broad spectrum of factual situations. *See* discussion in *D* ____ *R* ____ v. *Mitchell,* 456 F.Supp. 609, 620-624 (D. Utah 1978).

The phrase "amount, duration and scope" is repeated six times in § 1396a(a)(10) and is repeated several more times in the statute. *See*, § 1396a(a)(14), § 1396a(f), § 1396b(a)(1) and § 1396d(a). The Act nowhere defines what is meant by "amount, duration, or scope" of "medical assistance" and it must be concluded that each state has wide latitude, subject only to § 1396a(a)(17), in establishing standards of medical assistance which may reflect limitations by "amount, duration, or scope" of the care and services to be provided under the state's plan.[28]

The practice of the Secretary of the United States Department of Health, Education and Welfare who has approved Title XIX state plans which vary widely in the specifications of covered services and types of limitations on benefits for which funds are available is in accord with this interpretation of the Act. *See*, 2 CCH *Medicare and Medicaid Guide* ¶ 15,501 *et seq.*, and particularly ¶ 15,582 for the State of Illinois. The Secretary has approved the Illinois State plan and the Illinois Department of Public Aid (I.D.P.A.) has promulgated detailed rules and regulations for medical providers which identify the exclusions and limitations applicable to the service categories incorporated in the State's plan. In the Addendum to this brief I.D.P.A.'s general rules applicable to all providers and specific rules for physicians and hospitals are set out in pertinent part. (Add. 7a-67a).

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[28] In *Virginia Hospital Association* v. *Kenley*, 427 F. Supp. 781 (E.D. Va. 1977), the court upheld a Virginia regulation which limited Medicaid reimbursement for hospital visits to a total of 21 days per year. Judge Merhige held that such limits were not violative of either the comparability requirements of 42 U.S.C. § 1396a(a)(10) or the best interest requirements of 42 U.S.C. § 1396a(a)(19). The court found that, even though some recipients required "medically necessary" hospital treatment in excess of 21 days, Virginia's limit was justifiable under the broad standard of discretion states have to allocate their available Medicaid funds "as far as practicable" under 42 U.S.C. § 1396. The court also held that under applicable federal regulations [42 C.F.R.§ 440.230] the state may set reasonable limitations in defining what services will be provided. *Id.* at 783-785.

ILL. MED. ASSISTANCE PROGRAM, Rule 102, *General Policy and Procedure*, provides, in relevant part, that "The Department reserves the right to determine the necessity of providing medical care." (Add. 7a.). Rule A-203, *Physician's Services*, defines "covered services" as "those reasonably necessary medical and remedial services which are recognized as standard medical care required because of illness, disability, informity, or impairment, and which are necessary for immediate health and well-being." (Add. 13a). Rule A-204 states the "Services for which medical necessity is not clearly established are not covered in the Medical Assistance Program," (Add. 13a), and thereafter lists nineteen items which are excluded from coverage. Rule A-205.1, *Termination of Pregnancy—Induced Abortions*, reflects the ruling of Judge Grady at issue on this appeal.

Defendant Miller respectfully submits that this analysis satisfactorily establishes that the Medicaid statute does not mandate the inclusion of all "medically necessary services" in a state Medicaid plan and that Illinois' plan reserves the right to make determinations of necessity.

B.

Neither Title XIX Nor Regulations of the Department of Health, Education and Welfare Require the Funding of All "Medically Necessary" Abortions.

The Court in *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979) found that Title XIX does not mandate the funding of every imaginable medical service, treatment or procedure deemed "necessary" by a medical provider. However, based upon its reading of 42 U.S.C. § 1396a(a)(17) and Department of Health, Education and Welfare (H.E.W.) regulation 42 C.F.R. § 440.230 (1978), the *Preterm* court concluded that

under Title XIX Massachusetts had no authority to limit "medically necessary" abortions to those "necessary to prevent the death of the mother" and cases of pregnancy resulting from forced rape and incest. 591 F.2d 121, 126-127. The Seventh Circuit agreed with the reasoning and conclusion of the *Preterm* court. *Zbaraz* v. *Quern, supra*, 596 F.2d at 198-199.

This reading of the Medicaid statute by the *Preterm* court, and its adoption in *Zbaraz* II, stemmed primarily from its interpretation of 42 C.F.R. § 440.230(c)(i). According to the terms of 42 C.F.R. § 440.200, H.E.W. intended the provisions of Subpart B of Part 440 to specifically implement the following statutory provisions: § 1396a(a)(10), regarding comparability of services; § 1396a(a)(13)(B) and (C), prescribing the amount, duration and scope of services to be provided[29]; § 1396a(a)(22)(D), assuring quality of services; and § 1396f, regarding religious beliefs.

Significantly, § 440.230 does not have as its stated purpose implementation of § 1396a(a)(17) of the Act which is the primary measure against which any state plan limitation must be tested. The language of § 1396a(a)(17) "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act." *Beal* v. *Doe, supra*, 432 U.S. at 444. Director Miller reads § 440.230 (a) as placing limits on the "amount and duration" of "medical assistance" which a state, *ab initio*, has determined to provide as part of "required service" pursuant to § 1396a(a)(17). Thus § 440.230 provides, in part:

> (a) The plan must specify the amount and duration of each service *that it provides*. (emphasis added)

The language in § 440.230 which the *Preterm* Court seized upon comes later in the regulation, and then, only with respect to services within the ambit of a state plan:

[29] It should be noted, however, that § 1396a(a)(13)(B) and (C) include no references at all to "amount, duration, or scope" of services to be provided.

> (c)(1) The medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 [for the categorically needy] and 440.220 [for the medically needy] to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

"Required service" as found in § 440.230(c)(1) is simply a reference to the broad general categories of services in 42 U.S.C. §§ 1396a(a)(13)(b) and 1396d(a)(1)-(5).[30] "Title XIX makes no reference to abortions, or, for that matter, to any other particular medical procedure." *Beal* v. *Doe, supra*, 432 U.S. at 444. Nowhere in the regulations is abortion mentioned as a "required service."

By disregarding the relationship between 42 U.S.C. § 1396a(a)(17) and 42 C.F.R. § 440.230, as set forth above, the Court in *Preterm* agreed with the plaintiffs there that "the limitations imposed by Massachusetts on abortion services render those services insufficient in "amount, duration and scope" to reasonably achieve their purpose, and that the limitations are based solely on the type of medical condition involved rather than on determinations of medical necessity." *Preterm, Inc.* v. *Dukakis, supra*, 591 F.2d at 126. The Court reasoned instead:

> It could perhaps be argued that the Massachusetts plan reserves abortion services to those in greatest need—women who will die without an abortion—and denies it to those who need it less—women who will suffer damage to their health, no matter how grievous, but who will survive without the abortion. But we do not believe that the Medicaid Act contemplates or sanctions anything

[30] In *District of Columbia Podiatry Society* v. *District of Columbia*, 407 F. Supp. 1259, 1265 (D.D.C. 1975), the court, interpreting 45 C.F.R. § 249.10(a)(5)(i) [re-codified as 42 C.F.R. § 440. 230], held that the regulation is "intended to give the states the discretion to 'specify the amount and duration of each item of medical care and services that will be provided.'" The court upheld the refusal to provide all podiatrist services under the District of Columbia's Medicaid program.

> so stark. When a state singles out one particular medical condition—here, a medically complicated pregnancy—and restricts treatment for that condition to life and death situations it has, we believe, crossed the line between permissible discrimination based on degree of need and entered into forbidden discrimination based on medical condition. *Id.*

In Part III, *supra*, Defendant Miller discussed the concept of "medical necessity" as it relates to the obligation of the states under Title XIX and the role of the Medicaid physician who is free and encouraged to provide alternative modes of treatment to health problems which are treatable during pregnancy without recourse to abortion. The *Preterm* Court's analysis fails to appreciate the uniqueness of pregnancy as involving the treatment of two patients, the uniqueness of abortion as being the only medical procedure which results in the termination of life, and the availability of alternative modes of treatment for health-impairing illness and disease occurring during a pregnancy and which are treatable without recourse to abortion.

Pregnancy is not a disease. A limitation on abortion funding is not a denial or reduction in the "amount, duration or scope" of a required service to a recipient "solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230 (c)(1). It is a limitation placed on a particular *procedure*, not a *required service*, "because" of the unique aspect of pregnancy and abortion involving as they both do fetal life, a legitimate and protectable state interest. If a state refused to provide funds for an abortion to an indigent pregnant women suffering from thrombophlebitis and *also* refused to provide her with medication to prevent the formation of clots or refused to pay for hospitalization or bed rest, then it could truly be said that the state limitation was "'unreasonable' and wholly '[in]-consistent' with the objectives of the Act", constituting "forbidden discrimination" under § 440.230. *Preterm, Inc.* v. *Dukakis*,

supra 591 F.2d 121, 126. However, since nothing in *Preterm* or in this case suggests that either Massachusetts or Illinois would refuse to fund alternative modes of treatment, or that fetal life is not a protectable state interest, the conclusion that abortion funding limitations constitute an *arbitrary* denial or reduction in the amount, duration or scope of a required service is unwarranted.

"Absent such a showing" the Court should not presume "that Congress intended to condition a State's participation in the Medicaid program on its willingness to undercut [its important interest in fetal life] by subsidizing the costs" of non-"life-preserving" abortions for indigent women who have health problems treatable without recourse to abortion by treatment and care which a state is willing to fund. *Beal* v. *Doe*, *supra*, 432 U.S. at 446.

Some physicians, despite the existence of alternative modes of treatment for pregnancy complications falling short of life-threatening circumstances, may not value fetal life to the same extent as does the state and may insist on exercising their professional prerogative to perform an abortion instead. That is the physician's right. However, to the extent that the physician is unwilling to perform the procedure without payment by the state, he has no right to use the doctor-patient relationship as a sword to compel the state to abandon its policy favoring fetal life. Illinois' refusal to indiscriminately fund all abortions deemed "medically indicated" or "necessary for the preservation of the life or the physical or mental health of a woman seeking such treatment . . . exercised in the light of all factors relevant to her health" (R. 124) is a legitimate prerogative of the state in its administration of a non-comprehensive welfare program. The refusal to fund is not, without more, active state interference in the doctor-patient relationship. P.A. 80-1091 reasonably encourages childbirth over abortion without militating against maternal health. By its terms, Title XIX does not require otherwise.

V.

THE HYDE AMENDMENT ALTERS THE STATE'S DISCRETIONARY AUTHORITY UNDER TITLE XIX TO FUND ALL "MEDICALLY NECESSARY" ABORTIONS.

The United States Court of Appeals in *Zbaraz II* found that the 1978 and 1979 versions of the Hyde Amendment, Pub. L. 95-205, 91 Stat. 1460 [Add. 4a-5a] and Pub. L. 95-480, 92 Stat. 1586 [Add. 5a-6a], though enacted as part of annual appropriation measures, were properly interpreted as substantive modifications of the state plan requirements of Title XIX and its implementing regulations. *Accord, Preterm, Inc.* v. *Dukakis*, 519 F.2d 121 (1st Cir. 1979), *cert. denied, sub nom., Preterm, Inc.* v. *King*, ____ U.S. ____, 99 S.Ct. 2182 (1979). The *Zbaraz* Court rejected plaintiffs' contention that, as the Hyde Amendment was simply an appropriation measure affecting federal funding of abortions, Congress intended to shift the costs of subsidizing abortions to the states. As noted in Part IV(B), *supra*, Defendant Miller disagrees with the Court of Appeals' construction of Title XIX as requiring the funding of all "medically necessary" abortions. Thus while the *Zbaraz II* court viewed the Hyde Amendment as working a substantive modification to a *mandatory* provision of the Medicaid statute, Defendant Miller submits that the correct view is that the Hyde Amendment altered the State's *discretionary authority* under Title XIX regarding the funding of non-Hyde Amendment abortions.

A.

The Hyde Amendment Is Substantive Legislation Amending Prior Law.

As a general rule, repeal or amendment by implication of a prior substantive law is disfavored. *Morton* v. *Mancari*, 417 U.S. 535, 549 (1974); *Tennessee Valley Authority* v. *Hill*, 437 U.S. 153, 98 S.Ct. 2279, 2299 (1978). However, if "the intention of the legislature to repeal [is] clear and manifest."

Posadas v. *National City Bank*, 296 U.S. 497, 503 (1936), and if "the earlier and later statutes are irreconcilable," *Morton* v. *Mancari, supra*, 417 U.S. at 551, then the new law results in the old law giving way.

The key is always to discern the intention of the legislature. While on its face, the Hyde Amendment may appear to be simply an appropriation measure (" . . . [N]one of the funds provided by this joint resolution . . . ", Pub. L. 96-123, Sec. 109), such an interpretation would arguably have the effect of "imposing an obligation on the states to fund the total cost of non-Hyde Amendment therapeutic abortions, a result not consonant with the basic policy of the Medicaid system." *Preterm, Inc.* v. *Dukakis, supra*, 591 F.2d at 128. Thus resort to the legislative history of the Hyde Amendment is required to ascertain what Congress intended to accomplish by enactment of this funding restriction. *Id.*

"A fair-minded reading of the lengthy and often highly emotional floor debates in both houses compels the conclusion that Congress intended to alter the scope of Title XIX in regard to abortions." *Zbaraz* v. *Quern, supra*, 596 F.2d at 200. During the debates "no one, whether supporting or opposing the Hyde Amendment, ever suggested that state funding would be required." *Id.* In the early debates surrounding Pub. L. 94-493, 90 Stat. 1432, 1434 (1976) Representative Schroeder, an opponent of the law, acknowledged the effect which the act would have upon the states:

> "Each of our States will suffer the consequences of the action we take here today—a burden they can ill afford. [referring to the greater costs of funding child birth].
>
> In addition, retention of the Hyde Amendment would interfere with existing State statutes on use of public funds for abortions. Forty-seven States and the District of Columbia now permit medicaid reimbursement for abortions, but the Hyde amendment would prevent them from following their own State laws and guidelines. The result would be administrative chaos and increased litigation. 122 CONG. REC. H 8635 (daily ed. August 10, 1976).

Were the Hyde Amendment simply viewed as an appropriation measure, there would have been no occasion for Representative Schroeder to speak of "interference" with state programs. Moreover, it may not be fairly argued that Congress as a whole was unaware of the fact the Hyde Amendment constituted substantive legislation. *Cf., Tennessee Valley Authority* v. *Hill, supra*, 98 S.Ct. at 2300. Both supporters and opponents of the amendment acknowledged that it would have a substantive impact.[31]

The question thus becomes what impact precisely did the Hyde Amendment have. Is the Hyde Amendment clearly irreconcilable with the prior provisions of Title XIX?

B.

The Hyde Amendment Is Irreconcilable With The Discretion Congress Vested In Participating States To Determine The Extent of Medical Assistance To Be Provided In A State Plan.

Under 42 U.S.C. § 1396a(a)(17), as originally enacted, Congress intended to grant participating states wide latitude in structuring their state plans and making determinations regarding the amount, duration and scope of medical assistance to be provided. If, prior to the Hyde Amendment, a state determined that abortions were to be provided under its state plan, nothing in the Medicaid statute was a bar to such services. By including a particular item in its state plan, Congress intended that the state would be entitled to federal reimbursement according to the statutory formula for the costs incurred in providing such care. 42 U.S.C. §§ 1396b(a) and 1396d(b).

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[31] *See*, remarks of Congressman Hyde, at 123 CONG. REC. H 6083 (daily ed. June 17, 1977); *Id.* at 6088 (Rep. Eckhardt); *Id.* at 6090 (Rep. Mazzoli); 123 CONG. REC. S 11035 (daily ed. June 29, 1977) (Sen. Brooke) ("Mr. President . . . Such restrictions are a blatant case of legislating in an appropriations bill").

The Hyde Amendment is irreconcilable with 42 U.S.C. § 1396a(a)(17) because the effect of the amendment is to strip states of the discretionary authority granted them under the prior law insofar as abortion funding is concerned. While the Hyde Amendment leaves states free under state law to fund abortions, no state is free to include non-Hyde Amendment abortions in its Title XIX state plan and receive federal financial participation.

This conclusion is supported by the comments of Representative Schroeder, cited above, which accurately reflect the pre-amendment state of the law. States were permitted, but not required, to fund abortions. Withdrawal of federal funding "would prevent" funding of abortions not covered by the amendment under state Medicaid plans since the federal law would "interfere" with those plans.

Whether the legislators during the 1977 or 1978 debates realized that the Hyde Amendment was specifically irreconcilable with 42 U.S.C. § 1396a(a)(17) is difficult to say. Any uncertainty, however, appears to have vanished during the most recent debates over appropriations for the year ending September 30, 1980. Senator Jesse Helms, a proponent of Pub. L. 96-123, Sec. 109, 93 Stat. 923, stated:

> Mr. President, Congress enacted medicaid into law in 1965 when the vast majority of States declared abortion a crime except when needed to save the mother's life. Therefore, the medicaid title could not have been intended as a mandate to the States to fund "medically necessary" abortions beyond those necessary to preserve the mother's life. 125 CONG. REC. S 14496 (daily ed. Oct. 12, 1979).

Representative Donnelly made a similar observation:

> We do not intend to restrict the power of the States to refuse to pay for abortions to the extent they deem appropriate . . . The States are absolutely free to fund or refuse to fund abortions as they see fit, as they always have been. Whether the States fund or refuse to fund abortions is not a matter dictated by the Social Security Act or its

> regulations and, until such time as the Social Security Act is amended by Congress to require the States to fund abortions, the States are not required to do so. 125 CONG. REC. H 9885 (daily ed. Oct. 30, 1979).

See also, the statement of Senator Percy, an opponent, acknowledging that the Medicaid Act "does not even require a State to fund [abortions]." 125 CONG. REC.S S 9873 (daily ed. July 19, 1979).

Given the clear intent of Congress to substantively amend the scope of Title XIX with regard to abortions, and in view of the repugnancy between such a limitation and the freedom states otherwise have under § 1396a(a)(17) to determine the extent of medical assistance to be provided, Defendant Miller submits that the judicial criteria for finding a substantive statutory modification have been met.

C.

Congress Did Not Intend To Cause A Shifting Of The Costs Of All Non-Hyde Amendment Abortions To The States.

An alternative theory regarding the nature of the Hyde Amendment considered by the court below is that the Hyde Amendment, as an appropriation measure, only affects federal funding of abortions and has no substantive impact upon Title XIX state plan requirements found in 42 U.S.C. § 1396a *et seq.* The effect of this theory, if true, would be to work a shifting of the responsibility of funding all "medically necessary" non-Hyde Amendment abortions to the States on the assumption that Title XIX contains a requirement that mandates the funding of all "medically necessary" abortions. This cost-shifting rationale is wholly unsupported by the debates: "Nor is there any suggestion in the Congressional debates that the Hyde Amendment would alter the basic scheme of federal-state sharing of Medicaid expenses." *Zbaraz* v. *Quern, supra,* 596 F.2d at 200. Acceptance of the cost-shifting rationale necessarily requires a finding that Congress intended to repeal, *pro tanto,* §§ 1396b(a) and 1396d(b) which govern payments to the states. If this was the intent, Congress as a body was certainly not aware of it, and absent such awareness, no clear and manifest intent to repeal the basis of the federal-state compact can be found. *Tennessee Valley Authority* v. *Hill,* 437 U.S. 153, 98 S.Ct. 2279, 2299-2300 (1978).

This problem has been noted by commentators who have analyzed the various theories accepted by the lower federal courts in ruling on Hyde Amendment related litigation. One commentator's observations are particularly apt:

> The shifting responsibility theory conflicts with the concept of cooperative federalism. For example, in *Smith* v. *Ginsberg* [Civ. No. 75-0380 (S.D. W. Va. May 9, 1978)] the United States District Court for the Southern District of West Virginia issued an injunction requiring the state to pay for all medically necessary abortions under the *Bolton* test. The court stated that the unavailability of federal reimbursement did not obviate the state's obligation to provide funds for all necessary abortions. The holding in *Smith* places the states in the situation of having voluntarily become a part of the medicaid system, only to have the federal funds withdrawn. Terminating federal funds, which are the foundation of the medicaid program, produces hostile, not cooperative federalism. Under the shifting responsibility theory, Title XIX forces the states to spend their own money without hope of federal assistance. Thus, while federal officials refuse reimbursement, a state would be required to provide services that it considers contrary to public policy. Note, *Limiting Public Funds For Abortions: State Response To Congressional Action,* 13 SUFFOLK U.L. REV. 922, 951 (1979).

Given the total absence in the debates of any indication that the Hyde Amendment would shift to the states the burden of funding under Title XIX all abortions which the federal government refused to fund, this Court should reject any theory

which characterizes the Hyde Amendment as merely an appropriation measure affecting only one of the two partners in the fiscal partnership known as the Medicaid program.

Therefore, unless there is a constitutional right to a publicly funded abortion not "necessary for the preservation of the life of the woman seeking such treatment," plaintiffs' challenge to the validity of P.A. 80-1091 must fail.

VI

P.A. 80-1091 IS CONSISTENT WITH THE FOURTEENTH AMENDMENT'S GUARANTEE OF DUE PROCESS AND EQUAL PROTECTION OF THE LAWS.

If the Court accepts the reasoning of Director Miller that the plaintiffs' Title XIX claims are without merit, then it is appropriate that the Court should proceed to review the ruling of Judge Grady below that the federal and state abortion funding limitations are violative of the Fifth and Fourteenth Amendment to the United States Constitution. As defendant has already noted herein, the Fifth and Fourteenth Amendment questions do not materially differ. *Bolling* v. *Sharpe*, 347 U.S. 497 (1954) Both the state and federal statutes spring from the same legislative purpose—the protection of fetal life. Each statute's legislative history reflects the clash between those forces favoring and opposing the protection of this legitimate state interest in the context of medical assistance programs for the indigent. The concept of "medically necessary" abortions was debated in both the federal and state legislative forums and was rejected in both as being so amorphous as to permit abortion on demand. Finally, federal and state legislators who advocated passage of the legislation at issue were convinced that they were acting within the parameters of the Constitution in view of this Court's decision in *Maher* v. *Roe*, 432 U.S. 464 (1977), leaving such questions to the legislature. Director Miller submits that the question of governmental funding of all

"medically necessary" abortions is one best left to the legislature involving as it does a difficult policy choice over which reasonable men and women may, and do, differ. By superimposing its own notion of what is reasonable on the government, the District Court erred and its decision should be reversed.

Following the analytical method of the District Court, Director Miller shall first discuss whether P.A. 80-1091 "operates to the disadvantage of some suspect class or impinges upon a fundamental right explicitly or implicitly protected by the Constitution." *San Antonio School District* v. *Rodriguez*, 411 U.S. 1, 17 (1973).

Plaintiffs asserted below that the right involved is the right to an abortion as guaranteed in *Roe* v. *Wade*, 410 U.S. 113 (1973) and that the *Roe* right to an abortion implicates a right to state funding if the abortion is deemed "medically necessary." The threshold task, therefore, is to characterize the right asserted and the relationship of that right to the statutory provision under challenge.

A.

There Is No Fundamental Right To Abortion Or To A State Funded Abortion Expressly or Implicitly Protected by the Fourteenth Amendment.

The Fourteenth Amendment does not expressly provide a right to an abortion or to public funding for an abortion. In *Roe* v. *Wade*, 410 U.S. 113 (1973) this Court established the principle that a pregnant woman enjoys a qualified right of privacy under the Fourteenth Amendment's Due Process Clause sufficient to bar state infringement upon her right to choose between childbirth and abortion or upon her physician's right to provide that abortion free from the threat of criminal penalties:

> This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. 410 U.S. at 153.

It is equally well-established that a state may constitutionally decline to pay for "the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents."[32] *Maher* v. *Roe, supra,* 432 U.S. at 469 (1977).

The District Court found, and defendant contends here, that "the right recognized in *Roe* is not an affirmative right to an abortion, but is simply a right to make and effectuate the abortion decision." *Zbaraz* v. *Quern, supra,* 469 F.Supp. at 1217. The ruling in *Maher* v. *Roe* is controlling on the proper characterization of the *Roe* right and its relationship to state allocation of welfare benefits:

> [T]he right in *Roe* v. *Wade* can be understood only by considering both the woman's interest and the nature of the State's interference with it. *Roe* did not declare an unqualified "constitutional right to an abortion," as the District Court seemed to think. Rather, the right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy. It implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds.
>
> * * *

[32] *See also, Weinberger* v. *Salfi,* 422 U.S. 749, 771-772 (1975) ("... [A] non-contractual claim to receive funds from the public treasury enjoys no constitutionally protected status."); and *Lavine* v. *Milne,* 424 U.S. 577, 584 n.9 (1976) ("Welfare benefits are not a fundamental right, and neither the State nor the Federal Government is under any sort of constitutional obligation to guarantee minimum levels of support.").

> The indigency that may make it difficult—and in some cases, impossible—for some women to have abortions is neither created nor in any way affected by the Connecticut regulation.
>
> * * *
>
> There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy. 432 U.S. at 473-475.

The principle announced in *Maher* is as applicable to state laws withholding funding of "medically necessary" abortions as it is to limitations placed on funding of "elective" abortions. Either the *Roe* right is a sword with which its holder can attack any "state encouragement of an alternative activity consonant with legislative policy," *Id.* at 475, or it is a shield to protect its bearer "against state interference with certain aspects of an individual's personal 'privacy.'" *Id.* at 472. The Illinois statute "places no obstacles—absolute or otherwise—in the pregnant woman's path to [a medically necessary] abortion." *Id.* at 474. Plaintiffs here may encounter difficulty effectuating their decision to abort not because of P.A. 80-1091, but because of their indigency. *Zbaraz* v. *Quern, supra,* 469 F.Supp. at 1217. P.A. 80-1091 does not deny to pregnant indigent women seeking "medically necessary" abortions medical assistance benefits in general or medical assistance benefits for alternative modes of treating the complications of pregnancy where a physician is unable to reasonably certify an abortion as necessary to preserve the woman's life.

The *Maher* court acknowledged that "[t]he constitutionality of [a distinction between abortion and other procedures] will depend upon its degree and the justification for it," *Maher* v. *Roe, supra,* 432 U.S. at 473. Defendant Miller submits that the State's interest in fetal life in conjunction with its willingness to provide alternative care for the protection of maternal health justifies the distinction between "medically necessary" abortions and abortions "necessary for the preservation . . . of life."

Maher, therefore, is dispositive of the claim that implicit in the Fourteenth Amendment is a fundamental right to a state funded abortion within the context of a non-comprehensive medical assistance program for the indigent. Any doubts which may linger because this case, unlike *Maher*, involves some degree of medical need, should be resolved in favor of the State in light of the ruling in *Poelker* v. *Doe*, 432 U.S. 519 (1977). In *Poelker* this Court approved, over constitutional challenges, a policy and practice followed by two city owned hospitals in St. Louis, Missouri, that prohibited the performance of abortions in the hospitals unless "there was a threat of grave physiological injury or death to the mother." *Id.* at 520. In the lower court opinion, it is clear that this policy was interpreted to mean "to save the mother's life." *Doe* v. *Poelker*, 515 F.2d 541, 543 (8th Cir. 1975). The city's standard for medical necessity was identical to that contained in the Hyde Amendment and in P.A. 80-1091, and was far more restrictive than the "medically necessary" standard advocated by the plaintiffs. Yet the *Poelker* Court stated that "the constitutional question presented here is *identical in principle* with that presented by a State's refusal to provide benefits for abortion while providing them for childbirth." (emphasis added) *Id.* at 521.

Accordingly, neither the Hyde Amendment nor P.A. 80-1091, by restricting the funding of abortions to those "necessary for the preservation of . . . life," can be said to infringe upon any fundamental right of indigent women to secure public funding for all "medically necessary" abortions. This conclusion is inescapable from the principles central to the holdings in *Maher* and *Poelker*. Therefore, "[i]n the context of state funding of abortions, the right recognized in *Roe* v. *Wade* does not require the strict scrutiny that ordinarily would be triggered by the presence of a fundamental right within the scope of traditional Fourteenth Amendment analysis." *D*____ *R*____ v. *Mitchell*, 456 F. Supp. 609, 613 (D. Utah 1978), *appeal pending*, No. 78-1675 (10th Cir.); *accord*, *Zbaraz* v. *Quern*, *supra*, 469 F.Supp. at 1217.

As plaintiffs' complaint includes a claim that indigent women and their Medicaid physicians have a due process right to a state funded "medically necessary" abortion, it is appropriate to discuss the applicability of the Due Process Clause to the issues involved.

B.

The *Roe* v. *Wade* Right to Privacy May Not Be Transmuted On Substantive Due Process Grounds Into A Right To Public Funds For Abortions.

While *Roe* v. *Wade* may be seen as authorizing a limited resurrection of discarded notions of substantive due process characterized by decisions such as *Lochner* v. *New York*, 198 U.S. 45 (1905), such analysis is appropriate, if at all, only in instances of a "complete abridgment of a constitutional freedom." *Roe* v. *Wade*, *supra*, 410 U.S. at 170 (Stewart, J. concurring). Criminal abortion laws meet this test because of the extreme and compulsive nature of the state action involved. Generally, however, in a non-criminal setting and particularly in the setting of social welfare and economic legislation, due process analysis is avoided by the Court since it is tantamount to a judicial arrogation of legislative power.[33] In *Ferguson* v. *Skrupa*, 372 U.S. 726, 731 (1963), the Court referred to "our abandonment of the use of the 'vague contours' of the Due Process Clause to nullify laws which a majority of the Court believed to be economically unwise . . . We refuse to sit as a 'super-legislature' to weigh the wisdom of legislation."

It is precisely a weighing of the wisdom of P.A. 80-1091 which a due process claim invites. The Court, sitting as a "super-legislature," would weigh the woman's interest in her health, the physician's interest in professional discretion, the

[33] See, R. BERGER, GOVERNMENT BY JUDICIARY 249-282 (1977)

state's interest in fetal life, and the economics of abortion versus childbirth. The plaintiffs would urge the Court, sitting as a legislature, to determine that the state's interest in fetal life is outweighed by the women's concern for her health and the physician's willingness to abandon one of his two patients in the name of "medical necessity," and that the economics of the situation favor funding of abortions since that choice is less costly than paying for the expenses of childbirth. Then, presumably, based upon its own notions of what is wise policy, the Court would decide whether or not to fund all "medically necessary" abortions. It is respectfully submitted that such an approach is ill-conceived under the circumstances of this case and prior decisions of this Court.

Defendant Miller submits that the *Maher* court has limited the applicability of the doctrine of substantive due process to instances of "governmental intrusion, physical coercion and criminal prohibition of . . . [and] state interference with certain aspects of an individual personal 'privacy'." 432 U.S. at 471-472. The issue in this case as in *Maher* is not suitable for due process analysis since none of the indicia noted above are present. This is a case involving allocation of state funds in a manner deemed by the Illinois legislature to protect a legitimate state interest in fetal life without thereby compromising the State's interest in maternal health. The plaintiffs' due process right to privacy is no more or less affected by the legislation here than the *Maher* plaintiffs' rights were affected by the Connecticut regulation at issue there.

Moreover, when a woman asks the state to finance her abortion, her decision to have an abortion is no longer a private matter between her and her physician. When a woman and her physician assert a right to public funds, the constitutional focus switches from the individual's need for protection against undue state interference to a democratic society's need for collective judgments reflecting the policies and values of the community as a whole. The responsibility for this latter function has been committed in our system of government to the legislature.

The Court in *Maher* v. *Roe* recognized that the constitutional focus may vary depending upon the nature of the state action. The privacy right in *Roe* v. *Wade* "implies no limitation on the authority of the State to make a value judgment favoring childbirth over abortion and to implement that judgment by the allocation of public funds." *Maher* v. *Roe*, *supra*, 432 U.S. 473-474. Substantive due process is no limit on the state's fiscal autonomy to choose how to spend its tax dollars, even where the choice will require a greater rather than a lesser expenditure of public funds. The shortcomings of a substantive due process approach were expressly adverted to in *Maher*:

> Our conclusion that the Connecticut regulation is constitutional is not based on a weighing of its wisdom or social desirability, for this Court does not strike down state laws "because they may be unwise, improvident, or out of harmony with a particular school of thought." *Williamson* v. *Lee Optical Co.*, 348 U.S. 483, 488, 75 S.Ct. 461, 464, 99 L.Ed. 563 (1955), quoted in *Dandridge* v. *Williams*, *supra*, 397 U.S. at 484, 90 S.Ct. at 1161. Indeed, when an issue involves policy choices as sensitive as those implicated by public funding of nontherapeutic abortions, the appropriate forum for their resolution in a democracy is the legislature. We should not forget that "legislatures are ultimate guardians of the liberties and welfare of the people in quite as great a degree as the courts." 432 U.S. at 479-480 (citation omitted).

While some individuals may reasonably believe that the policy choice of the Illinois General Assembly to restrict abortion funding is harsh and unwise, or as the District Court felt, "cruel," 469 F.Supp. at 1221, this alone is insufficient justification to usurp the rightful exercise of the legislative function from the legislature in the absence of a complete abridgment of constitutional freedom. Director Miller submits that the Court should defer to the collective "wisdom" of the community as expressed through its elected representatives in appraising P.A. 80-1091. The right to privacy should not be judicially transmuted on substantive due process grounds into a right to public funds for a "medically necessary" abortion.

C.

No Constitutional Rights Of Treating Physicians Are Infringed By A Policy Decision To Limit Abortion Funding To Life-Preserving Situations.

Unlike the statutes in *Roe* v. *Wade*, 410 U.S. 113 (1973) and *Doe* v. *Bolton*, 410 U.S. 179 (1973), P.A. 80-1091 does not intervene or intrude upon, "the right of the physician to administer medical treatment according to his medical judgment", *Roe* v. *Wade*, 410 U.S. at 165, or criminalize the physician's conduct should he perform an abortion not covered by the statute. The State's determination that it will not pay for certain "medically necessary" abortions does not amount to unconstitutional coercion forcing the physician to otherwise alter his professional judgment or to obstruct his administration of medical treatment based upon that judgment.

Participation by physicians in the Medicaid program is wholly voluntary. The impact of P.A. 80-1091 is solely to condition the terms upon which the physician may be reimbursed should he decide to participate in that program. Congress and the states leave that decision solely up to each practitioner. Non-payment of "medically necessary" abortions falling outside the scope of P.A. 80-1091 is not the only limitation which a doctor may experience when he chooses to leave the private sector for the public. The federal government under Title XVIII (Medicare) and state governments under Title XIX (Medicaid) have great latitude in setting the amount of reimbursement for covered procedures and deciding which procedures are covered in the first instance. *Beal* v. *Doe*, 432 U.S. 438 (1977).

As an example of constitutionally permissible regulation of the medical profession, the Court is directed to the well-reasoned opinion of the court in *Association of American Physicians & Surgeons* v. *Weinberger*, 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd*, 423 U.S. 975 (1975). Plaintiff-physicians

challenged the enforcement of the "Professional Standards Review Law", 42 U.S.C. § 1320c *et seq.*, legislation designed to regulate physician abuses in the Medicare and Medicaid programs. The act was intended by Congress to prevent unnecessary hospitalization and unnecessary surgery. Among the constitutional claims pressed by the doctors was that the statute was unconstitutionally "arbitrary and overbroad and interferes with the plaintiffs' right to practice medicine", 395 F. Supp. at 131.

The Court disagreed, stating, "The statute, however, does not bar physicians from practicing their profession but only 'provides standards for the dispensation of federal funds.' " 395 F.Supp. at 132. "The 'Professional Standards Review' Law does not prohibit a physician from performing any surgical operations he deems necessary in the exercise of professional skill and judgment. It merely provides that if a practitioner wishes to be compensated for his services by the federal government, he is required to comply with certain guidelines and procedures enumerated in the statute." *Id.* at 134.

The physicians also alleged that the act unconstitutionally interfered with the physician-patient relationship by having a chilling effect on the practice of medicine to the detriment of the patient. Again, the Court disagreed since the statute expressly set forth reasonable and flexible standards for patient care. 395 F.Supp. at 134-135. Finally, the Court rejected the claim that the law violated the physician's privacy rights as articulated in *Roe* v. *Wade* since the government was deemed to have a significant "interest in maintaining proper health care in an economical manner." 395 F.Supp. at 136. *Cf.*, *American Association of Councils of Medical Staffs of Private Hospitals, Inc.*, v. *Mathews*, 421 F.Supp. 848 (E.D. La. 1976), *vacated on other grounds*, 575 F.2d 1367 (5th Cir. 1978); *Lang* v. *Berger*, 427 F.Supp. 204 (S.D.N.Y. 1977).

Illinois does not directly intrude upon the practice of medicine, the physician-patient relationship, or the physician's right to privacy when it limits public funding for abortions to

those "necessary for the preservation of . . . life." The standard for funding of abortions under P.A. 80-1091 is reasonable given the state's interest in fetal life and the availability of alternative modes of treating the complications of pregnancy. The Illinois statute leaves the physician ample room to exercise his professional judgment should he elect to participate in the Medicaid program. The physician's hands are not tied. His freedom to practice medicine is not abridged since he is free to provide a "medically necessary" abortion to a patient without fear of criminal sanctions or other coercive measures.

The State does not monopolize the delivery of health care. However, within the health care system it does administer, the State has the authority to decide what will be a covered, reimbursable service, and this power does not amount to state interference with the practice of medicine. The physician remains free to treat his patients, whether in the private or public sector, and free to perform any abortion he deems appropriate or "medically necessary." The State is simply refusing to pay for abortions not necessary for the preservation of the mother's life by its enforcement of P.A. 80-1091.

D.

P.A. 80-1091 Creates No Suspect Classification Based On Wealth.

The limitations of P.A. 80-1091 do not involve invidious discrimination against a suspect class even though the denial of public funding for "medically necessary" abortions may be said to create a "wealth classification." *San Antonio School District* v. *Rodriguez*, 411 U.S. 1 (1973). The Constitution does *not* require absolute equality. *Douglas* v. *California*, 372 U.S. 353, 357 (1963). Most legislation classifies people in one way or another or discriminates between classes of people. However, it is only invidious discrimination which violates the Constitution.

Invidious discrimination has been defined as legislation that singles out certain traditionally deprived minorities for special treatment, and that works to their disadvantage. *San Antonio School District, supra,* 411 U.S. at 28. Suspect classifications include:[34] race (*Korematsu* v. *United States*, 323 U.S. 214 (1944)); alienage (*Graham* v. *Richardson*, 403 U.S. 365 (1971)); and national origin (*Hernandez* v. *Texas*, 347 U.S. 475 (1954)).

The essence of equal protection simply stated is that all individuals are entitled to a certain equality of treatment at the hands of government. The government is not constitutionally obligated to eliminate life's inequities. On the other hand, the state may not confer substantial benefits on one class of persons and simultaneously deprive another class of persons of the same benefits without justification.

Under the foregoing standards, the legislation in question does not involve invidious discrimination on the basis of wealth. The State has not conferred any benefit upon wealthy women that it similarly denies to indigent women. Rather, all women who become pregnant—rich or poor—are treated in an identical manner with respect to the availability of State funds for abortions. The State has merely chosen not to fund a particular *class of abortions* regardless of whether the woman involved be rich, poor, black, white, Spanish-speaking, or English-speaking. The fact that the more affluent woman can nevertheless obtain an abortion is not invidious discrimination. The same holds true for any benefit the State chooses not to provide. The more affluent will always be in a better position to escape the adverse consequences of such State decisions.

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[34] The *Rodriguez* court listed some of the traditional indicia of a suspect class: "a class . . . saddled with such disabilities, or subjected to such a history of purposeful unequal treatment or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process." 411 U.S. at 28.

As stated by Justice Harlan dissenting in *Douglas* v. *California*, 372 U.S. 353, 361-362 (1963):

> The States, of course, are prohibited by the Equal Protection Clause from discriminating between 'rich' and 'poor' *as such* in the formulation and application of their laws. But it is a far different thing to suggest that this provision prevents the State from adopting a law of general applicability that may affect the poor more harshly than it does the rich, or, on the other hand, from making some effort to redress economic imbalances while not eliminating them entirely.
>
> Every financial exaction which the State imposes on a uniform basis is more easily satisfied by the well-to-do than by the indigent. Yet I take it that no one would dispute the constitutional power of the State to levy a uniform sales tax, to charge tuition at a state university, to fix rates for the purchase of water from a municipal corporation, to impose a standard fine for criminal violations, or to establish minimum bail for various categories of offenses. Nor could it be contended that the State may not classify as crimes acts which the poor are more likely to commit than are the rich. And surely, there would be no basis for attacking a state law which provided benefits for the needy simply because those benefits fell short of the goods or services that others could purchase for themselves.
>
> Laws such as these do not deny equal protection to the less fortunate for one essential reason: the Equal Protection Clause does not impose on the States "an affirmative duty to lift the handicaps flowing from differences in economic circumstances." To so construe it would be to read into the Constitution a philosophy of leveling that would be foreign to many of our basic concepts of the proper relations between government and society. The State may have a moral obligation to eliminate the evils of poverty, but it is not required by the Equal Protection Clause to give to some whatever others can afford.

The holding of the Court in *Douglas* and *Boddie* v. *Connecticut*, 401 U.S. 371 (1971), that state payment of court

related fees for indigents may be constitutionally mandated is an exception to the general rule that legislative classification related to ability to pay are not suspect. In the absence of a fundamental right or government monopoly of a service, these exceptions will not apply. *Maher* v. *Roe*, *supra*, 432 U.S. at 471 n. 6. There is no fundamental right to Medicaid abortion, and Illinois does not have a monopoly on the means for terminating a pregnancy or providing health care.

The indigent woman is as free to seek and procure an abortion as her more affluent counterpart. The fact that her economic circumstances make that task a far more difficult proposition is not the State's doing. The State is not the cause (at least in a legal sense) of her plight. The decision of the State not to rescue her may seem to be a harsh decision, but it is one which is constitutionally permissible.

If a woman is poor and chooses to have a child, the State will pay for the expenses of childbirth. If a woman is poor and elects to have a "medically necessary" abortion, the State will not pay unless it falls within the standard of P.A. 80-1091. For purposes of equal protection analysis, the salient point is that the disparate treatment is not invidious. The distinction here is drawn between women of similar economic circumstance. The State has chosen to provide some benefits to the poor and not to provide others.

These principles have been ratified by the Supreme Court in *Maher* v. *Roe:*

> In a sense, every denial of welfare to an indigent creates a wealth classification as compared to nonindigents who are unable to pay for the desired goods or services. But this Court has never held that financial need alone identifies a suspect class for purposes of equal protection. 432 U.S. at 471.

It follows that the state's classification scheme singling out abortions necessary for the preservation of life for funding creates no suspect classification of individuals based upon wealth.

E.

Illinois Does Not Penalize The Decision to Abort By Funding Only "Life-Preserving" Abortions.

The "penalty analysis" implicit in application of *Shapiro* v. *Thompson*, 394 U.S. 618 (1969) and *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250 (1974) to the facts in *Maher* was specifically rejected by the *Maher* Court in the context of abortion funding.

> If Connecticut denied general welfare benefits to all women who had obtained abortions and who were otherwise entitled to the benefits, we would have a close analogy to the facts in *Shapiro*, and strict scrutiny might be appropriate under either the penalty analysis or the analysis we have applied in our previous abortion decisions. But the claim here is that the State "penalizes" the woman's decision to have an abortion by refusing to pay for it. *Shapiro* and *Maricopa County* did not hold that States would penalize the right to travel interstate by refusing to pay the bus fares of the indigent travelers. 432 U.S. at 474 n.8.

Government does not infringe upon the indigent's right to travel by "refusing to pay the bus fare of indigent travelers" whether travel is deemed necessary to "well-being" or not. Similarly, government incurs no supernumerary obligation to finance abortion deemed "medically necessary" in view of its contrary interest in protection of potential human life.

Illinois does not deny medical assistance benefits to women seeking a "medically necessary" abortion since it funds alternative modes of treating the complications of pregnancy. The speculation that P.A. 80-1091 will result in "increased maternal morbidity and mortality" is insufficient to support a finding that the State "penalizes" the woman's decision to abort given the availability of alternative treatment. *See*, discussion in Part III, *supra*.

F.

P.A. 80-1091 Is A Rational Means Of Protecting Legitimate State Interests.

The District Court, agreeing generally with the contentions of defendant in sections A through C of Part VI of this brief, properly determined "that P.A. 80-1091 should not be subject to strict judicial scrutiny." *Zbaraz* v. *Quern*, 469 F.Supp. 1212, 1218. Following the lead of this Court in *Maher* it measured P.A. 80-1091 under the less stringent test of "rationality," in order to determine whether the withholding of funds for "medically necessary" abortions violated the constitution.[35] It then purported to identify the interests advanced by the defendants in support of the funding limitation. The first interest it identified was the state's interest in "fiscal frugality." The State, however, never asserted that it had an interest in "fiscal frugality." *See*, R. 102, Defendant Quern's Memorandum of Law on the Constitutional Questions. The interest which the State did assert was the right to allocate welfare funds according to its own policies, regardless of cost, in order to protect a legitimate state interest. In this brief, Director Miller has labeled this as an interest in "fiscal autonomy," which arises out of a legislative responsiveness to the ethical concerns of the people of the State as to the uses put to their tax dollars.

The District Court found that the Illinois policy could not be rationally related to any interest in "fiscal frugality" since abortion is less costly than childbirth. 469 F.Supp. at 1218. The Court then considered the State's interest in the protection

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[35] The Court should not be misled by an inadvertent error on the part of the District Court, 469 F. Supp. at 1215 n.4, characterizing prior state regulations as incorporating a *Doe* v. *Bolton* definition of "therapeutic." The definition was part of a regulation imposed on the state agency by prior court rulings in this litigation. While the cover sheet of the regulations was dated January, 1976, the definitional page was inserted in 1978.

of the fetus through the encouragement of childbirth. *Id.* at 1219. While recognizing that this was a legitimate state interest under the Court's ruling in *Maher* and *Poelker*, the District Court purported to find a "crucial" distinction between the refusal to expend funds for "nontherapeutic" abortions and "medically necessary" abortions. Under the Court's view of the funding restriction "the mother may be subjected to considerable risk of severe medical problems, which may even result in her death," *id.*, by the failure of the State to fund all "medically necessary" abortions. This speculation as to medical risks was based wholly and uncritically upon the affidavits of certain physicians submitted by the plaintiffs in support of their motion for summary judgment. For a critique of those affidavits, see Part III, *supra*. The Court purported to make a finding of fact that "The effect of the [funding limitation] will be to increase substantially maternal morbidity and mortality among indigent pregnant women." *Id.* at 1220. This "fact" should have been weighed against the availability of alternative treatment (R.61, affidavit of Jasper Williams, M.D.) and the state's assertion that it did not second-guess the judgment of physicians regarding certification of an abortion as necessary for the preservation of life (R. 109, affidavit of Kenneth Wilson).

More significantly, the Court should have been hesitant to adopt a standard of "necessity" under which a physician would readily certify every other pregnant woman he treated as needing a "medically necessary" abortion (R.101, affidavit of Oren Richard Depp, III, M.D.).

Defendant submits therefore that the District Court erred in concluding that the State's legitimate interest in fetal life prior to viability was outweighed by the interest of indigent women for whom an abortion, in the opinion of their physician, is "medically necessary" as defined in the affidavits. The effect of the ruling is to overturn the holding in *Maher* v. *Roe* that a state need not fund nontherapeutic abortions for there is no practical difference between "medically necessary" abortions as defined by plaintiffs and elective abortion on demand.

The State's abortion funding statute is a rational means of protecting legitimate state interests. In sections A through C of Part VI of this brief Defendant Miller has demonstrated that the plaintiffs have no fundamental right to a publicly funded abortion where the physician determines that an abortion is "medically necessary" but not necessary for preservation of his patient's life. None of the traditional constitutional approaches which justify heightened judicial scrutiny are applicable to the case at bar. P.A. 80-1091 is not patently arbitrary or wholly lacking any rationale and it does not completely abridge a constitutional freedom. The act neither creates a suspect classification based on wealth, nor unconstitutionally penalizes the rights of pregnant indigent women in view of the availability of alternate modes of treating the complications of pregnancy. It establishes a policy of social welfare.

In *Dandridge* v. *Williams*, 397 U.S. 471, 486 (1970), this Court established the standard by which legislative classifications in the area of economics and social welfare are to be measured:

> In the area of economics and social welfare, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some 'reasonable basis,' it does not offend the Constitution simply because the classification 'is not made with mathematical nicety or because in practice it results in some inequality . . .' A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it . . . It is a standard that is true to the principle that the Fourteenth Amendment gives the Federal Courts no power to impose upon the States their economic view of what constitutes wise economic policy or social policy. (citations omitted).

Applying this standard to the Connecticut regulation governing the funding of non-therapeutic abortions, the Court in *Maher* v. *Roe* found that the State had a constitutionally permissible interest in protecting the potential life of the fetus which exists

throughout pregnancy, 432 U.S. at 478, and that the "subsidizing of costs incident to childbirth is a rational means of encouraging childbirth." 432 U.S. at 479. In addition demographic concerns were recognized as legitimate. 432 U.S. at 478 n.ll.

The debates on P.A. 80-1091 indicate that the Illinois legislators advanced each of the above identified state interests in support of the legislation. In addition, the Illinois legislators asserted an interest in fiscal autonomy arising from the moral beliefs of their constituents that abortion on demand should not be supported by tax dollars. Illinois State Senator Lemke, the sponsor of P.A. 80-1091 stated this interest in the following manner:

> My people don't want abortions being performed with their money. If it costs them more to support these children after they're born, they will pay that money gladly as long as it is properly used. (App. 64).

The legislation at issue in this case rationally furthers these legitimate state interests. The restriction on public funds for abortion to those "necessary for the preservation of . . . life" is rational since it prevents the unnecessary termination of fetal life without harming maternal health. It is rational to distinguish abortions from other medical procedures since "other procedures do not involve the termination of potential human life." *Maher* v. *Roe, supra,* 432 U.S. at 480. By encouraging childbirth and discouraging unnecessary abortions the state is avoiding the use of state funds in a manner thought to be unethical by its citizens. It is rational for the state to take into consideration ethical reservations regarding abortion held by its citizens because the ethical issue involves the most compelling interest of the state: "the interest in maintaining that respect for the paramount sanctity of life which has always been at the center of western civilization." A. Cox, The Role of the Supreme Court in American Government, 53 (1974).

In conclusion, Illinois has several legitimate interests which are advanced by P.A. 80-1091 including the interest in encouraging normal childbirth which the *Maher* court held to exceed the minimum level of scrutiny necessary to survive an equal protection challenge. For this reason Defendant Miller asks that the principles formulated in *Maher* v. *Roe,* as applied in *Poelker* v. *Doe,* be extended to this case. The application of *Maher* and *Poelker* to this case, defendant submits, requires the reversal of the ruling below that P.A. 80-1091 violates the Fourteenth Amendment's guarantee of equal protection of the laws.

CONCLUSION

Director Miller asks the Court to clarify the nature of the state's obligation to provide abortion funding under Title XIX of the Social Security Act, as passed and as modified by the Hyde Amendment. The Court should examine the *Doe* v. *Bolton* concept of "medical necessity" and find that it has no applicability to the process by which a state determines what specific medical procedures a state will fund within the context of a non-comprehensive program of medical assistance for the needy. In this respect the Court should clarify the dictum in *Beal* v. *Doe* that a regulation proscribing "medically necessary" abortions might run afoul of the requirements of Title XIX.

Director Miller requests that the Court weighs the affidavits of the physicians submitted in this case against the state's willingness to fund alternative modes of treatment for the complications of pregnancy and its reasonable interpretation of a "life-preservation" standard. Defendant submits that the affidavits do not support the conclusion that enforcement of P.A. 80-1091 will necessarily result in "increased maternal morbidity and mortality," and that the plaintiffs' concept of "medical necessity" is tantamount to abortion on demand.

The Court should reverse the ruling of the District Court holding Illinois' abortion funding limitation statute unconstitutional and reaffirm, in the context of this litigation, the principles underlying the ruling in *Maher* v. *Roe* and *Poelker* v. *Doe*. Those decisions clearly establish the following principles:

1. The fundamental right to privacy established in *Roe* v. *Wade* is a non-interference right, not an unqualified "constitutional right to an abortion" and certainly not a right to a state funded abortion on demand.

2. The limitation of state welfare funds for the payment of abortions does not impinge upon a woman's right to privacy.

3. A classification based upon indigency is not a "suspect classification."

4. The refusal to fund the exercise of a constitutionally protected right does not "penalize" the holder of that right.

5. The State has a "strong interest in potential human life" and in "protection of the fetus."

6. The encouragement of childbirth through governmental subsidy of costs incident to childbirth is a rational and constitutionally permissible means of protecting the State's "strong and legitimate interest in encouraging natural childbirth."

7. A city policy prohibiting the performance of abortions except where there is "a threat of grave physiological injury or death" is constitutionally indistinguishable from a state policy restricting Medicaid benefits for non-therapeutic abortions while providing them for childbirth.

In the alternative, should this Court uphold the ruling of the District Court, Director Miller requests that the District Court be directed to order the United States to reimburse the State of Illinois for all Title XIX abortions which it will be required to fund under the Court's ruling.

Respectfully Submitted,

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ADDENDUM

PUBLIC ACT 80-1091 (eff. Nov. 17, 1977)

AN ACT to amend Sections 5-5, 6-1 and 7-1 of "The Illinois Public Aid Code", approved April 11, 1967, as amended.

Be it enacted by the People of the State of Illinois represented in the General Assembly:

Section 1. Sections 5-5, 6-1 and 7-1 of "The Illinois Public Aid Code", approved April 11, 1967, as amended, are amended, the amended Sections to read as follows:

(Ch. 23, par. 5-5)

Sec. 5-5. Medical services.) The Illinois Department, by rule, shall determine the quantity and quality of the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services; (14) transportation and such other expenses as may be necessary; (15) medical treatment of rape victims for injuries sustained as a result of the rape, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the rape; (16) any other medical care, and any other type of remedial

care recognized under the laws of this State, *but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.* The preceding terms include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

* * * * *

The rules and regulations of the Illinois Department shall require that a written statement including the required opinion of a physician shall accompany any claim for reimbursement for abortions, or induced miscarriages or premature births. This statement shall indicate what procedures were used in providing such medical services.

* * * * *

(Ch. 23, par. 6-1)

Sec. 6-1. Eligibility requirements.) Financial aid in meeting basic maintenance requirements for a livelihood compatible with health and well-being, plus any necessary treatment, care and supplies required because of illness or disability, shall be given under this Article to or in behalf of persons who meet the eligibility conditions of Sections 6-1.1 through 6-1.6. *Nothing in this Article shall be construed to permit the granting of financial aid where the purpose of such aid is to obtain an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.*

Until August 1, 1969, children who require care outside their own homes, where no other sources of funds or insufficient funds are available to provide the necessary care, are included among persons eligible for aid under this Article. After July 31, 1969, the Department of Children and Family Services shall have the responsibility of providing child welfare services to such children, as provided in Section 5 of "An Act creating the Department of Children and Family Services, codifying its powers and duties, and repealing certain Acts and Sections herein named", approved June 4, 1963, as amended.

(Ch. 23, par. 7-1)

Section. 7-1. Eligibility requirements.) Aid in meeting the costs of necessary medical, dental, hospital, boarding or nursing care, or burial shall be given under this Article to or in behalf of any person who meets the eligibility conditions of Sections 7-1.1 through 7-1.3, *except where such aid is for the purpose of obtaining an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.*

(Emphasis added)

DEPARTMENTS OF LABOR, AND HEALTH, EDUCATION, AND WELFARE, APPROPRIATION ACT, 1977 PUBLIC LAW 94-439, 90 STAT. 1418, 1434 (Sept. 30, 1976)

SEC. 209. None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.

DEPARTMENTS OF LABOR, AND HEALTH, EDUCATION, AND WELFARE, AND RELATED AGENCIES, APPROPRIATION ACT, 1978—CONTINUING APPROPRIATIONS—PUBLIC LAW 95-205, 91 STAT. 1460 (Dec. 9, 1977)

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated out of any money in the Treasury not otherwise appropriated, and out of applicable corporate or other revenues, receipts, and funds, for the several departments, agencies, corporations, and other organizational units of the Government for the fiscal year 1978, namely:

SEC. 101. Such amounts as may be necessary for continuing projects or activities which were conducted in the fiscal year 1977, and for which appropriations, funds, or other authority would be available in the District of Columbia Appropriations Act, 1978 (H.R. 9005) as passed the House of Representatives or the Senate, but at a rate of operations not in excess of the current rate: *Provided,* That the Advisory Neighborhood Commissions shall be continued at an annual rate of not to exceed $500,000: *Provided further,* That the rate of operations for the Disaster Loan Fund of the Small Business Administration contained in said Act shall be the rate as passed the Senate.

Such amounts as may be necessary for projects or activities provided for in the Departments of Labor, and Health, Education, and Welfare, and Related Agencies Appropriation Act, 1978 (H.R. 7555), at a rate of operations, and to the extent and in the manner, provided for in such Act, notwithstanding the provisions of Sec. 106 of this joint resolution: *Provided,* That none of the funds provided for in this paragraph shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service; or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

Nor are payments prohibited for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures necessary for the termination of an ectopic pregnancy.

The Secretary shall promptly issue regulations and establish procedures to ensure that the provisions of this section are rigorously enforced.

DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS ACT, 1979 PUBLIC LAW 95-480, 92 STAT. 1567, 1586 (Oct. 18, 1978)

SEC. 210. None of the funds provided for in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service;

or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

Nor are payments prohibited for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures necessary for the termination of an ectopic pregnancy.

JOINT RESOLUTION [H.J. RES. 440] PUBLIC LAW 96-123, 93 STAT. 923, 926 (Nov. 20, 1979)

SEC. 109. Notwithstanding any other provision of this joint resolution except section 102, none of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service;

Nor are payments prohibited for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures necessary for the termination of an ectopic pregnancy.

Chapter 100

General Policy and Procedure

100. ILLINOIS MEDICAL ASSISTANCE PROGRAM

101. *Authority*

The Illinois Medical Assistance Program is the Federal-State public assistance program which implements Title XIX of the Social Security Act (Medicaid). It is administered by the Department of Public Aid under Article V of the Illinois Public Aid Code. The Department has statutory responsibility for the formulation of policy in conformance with Federal and State requirements.

102. *Objective*

The objective of the Medical Assistance Program is to enable eligible recipients to obtain essential medical care and services necessary to preserve health, alleviate sickness, and correct handicapping conditions. Such care and services are provided when they are not either available without charge or covered by health insurance or other third party resource.

Essential care and services are those which are generally recognized as standard medical services required because of disease, disability, infirmity or impairment. The Department reserves the right to determine the necessity of providing medical care in individual situations, with the determination based on recommendations of technical and professional staff, and advisory committees.

Both fiscal considerations and good administrative practice require the imposition of certain limitations and controls on the kind and amount of medical care and services covered in the Medical Assistance Program. Careful review of the subsequent material will enable the medical services provider to identify specific Program coverage and limitations.

110. PROVIDER PARTICIPATION

To receive payment for medical care, services, or supplies provided to Public Aid recipients, a provider must be approved for participation by the Department. To be considered for participation, a provider is to contact Illinois Department of Public Aid, Post Office Box 4034, Springfield, Illinois 62708. (See General Appendix 8 for appropriate telephone number.)

111. *Requirements*

Requirements for providers approved for participation include but are not limited to the following:

1) Notification to the Department, in writing, immediately whenever there is a change in any of the information which the provider previously submitted to the Department.

2) Allowance of recipients a freedom of choice in seeking medical care from any institution, agency, pharmacy, or person who is a participant in the Medical Assistance Program.

3) Allowance of recipients a freedom to reject medical care and treatment.

4) Provision of services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the grounds of race, color, or national origin and with the Rehabilitation Act of 1973 and Part 84 of the Federal Regulations which prohibit discrimination on basis of handicap.

5) Provision of services and supplies to recipients without discrimination on the basis of religious belief, political affiliation, or sex.

6) Provision of services and supplies to recipients in the same quality and mode of delivery as are provided to the general public.

7) Making of charges for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

8) Acceptance as payment in full the amounts established by the Department.

9) Acceptance of assignment of Medicare benefits for Public Aid recipients eligible for such benefits.

10) Use of Department designated billing forms for submittal of charges.

11) Maintenance and retention of business and professional records sufficient to fully and accurately document the nature, scope and details of the health care provided. (Refer to Section II for specific record content.)

Such records must be retained for a period of not less than three years from date of service or as provided by applicable State laws, whichever period is longer; except that, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.

12) Furnishing to the Department, in the form and manner requested, pertinent information regarding services for which charges are made.

13) Disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to recipients of Public Aid.

14) Holding confidential, and using for authorized program purposes only, all Medical Assistance information regarding recipients.

15) The provider shall comply with the requirements of applicable Federal and State laws and shall not engage in practices prohibited by applicable Federal and State law.

112. *Termination of Provider Participation*

A participating provider may terminate his participation in the Medical Assistance Program at any time. Written notification of voluntary termination is to be made to the Illinois Department of Public Aid, Post Office Box 4034, Springfield, Illinois 62708.

The Department may administratively terminate a provider from participation upon written notification. Such action precludes further payment by the Department for services provided recipients subsequent to receipt of the Department notice of intent to terminate. (See General Appendix 7A, Rules for Department Actions Against Medical Vendors, for actions on which termination may be based.)

The Department notification to the provider of intent to terminate his participation will include a Statement of Grounds and a statement of the right of the provider to request a hearing prior to termination.

During the hearing, payments on pending and subsequently received bills is withheld for up to 120 days (or longer if delay is caused by the provider or mutually agreed to by the Department and the provider).

120. RELATIONSHIP TO OTHER PROGRAMS

Payment can be made through the Medical Assistance Program only after all other known resources for payment, both private and government, have been explored and exhausted.

121. *Other Agency Resources*

State agencies other than the Department of Public Aid have responsibility for coordinating the provision of selected medical services under specified conditions. When a Public Aid recipient is eligible for the services of other agencies, such resources must be used first. Such agencies include, but are not limited to, those whose programs are described below.

University of Illinois Division of Services for Crippled Children

The Division of Services for Crippled Children provides for care and treatment of children from birth to age 21 who have crippling or potentially crippling conditions. Children who have one of the following conditions are to be referred to that Agency for evaluation, either directly by the provider or through the local Public Aid office.

1. Orthopedic handicaps
2. Neurological handicaps
3. Cardiac handicaps
4. Body deformities which are amenable to plastic surgery
5. Speech defects associated with congenital or acquired brain, oral, or pharyngeal defects
6. Hearing loss or deafness
7. Rheumatoid arthritis
8. Tracheo-esophageal fistula
9. Cystic fibrosis
10. Phenylketonurial

Chapter A-200

Physicians' Services

For consideration to be given by the Department to payment for physicians' services, such services must be provided in full compliance with both the general provisions contained in Chapter 100 and the policy and procedures set forth herein.

A-200. BASIC PROVISIONS

A-201. *Physicians Participation*

A Doctor of Medicine (M.D.) or Osteopathy (D.O.) who holds a valid Illinois (or State of practice) license to practice medicine in all its branches, is eligible for approval to participate in the Medical Assistance Program; however, special policy applies to the participation of physicians who receive salaries from hospitals and/or medical schools.

.1 Interns are not approved as participating physicians as the cost of their services is included in the hospital's reimbursable costs.

.2 Residents generally are excluded from participation on the same basis as interns; except that where, by terms of their contract with the hospital, they are permitted to and do bill private patients and collect and retain the payments received for their services, participation may be approved.

.3 Hospital based specialists who are salaried, with the cost of their services included in the hospital reimbursable costs, are not approved for participation. Participation may be approved for those physicians whose contractual arrangement with the hospital provides for them to make their own charges for professional services and they do, in fact, bill private patients and collect and retain payments made.

.4 Physicians holding non-teaching administrative or staff positions in hospitals and/or medical schools may be approved for participation in the provision of direct patient services if they maintain a private practice and bill, collect from, and retain payments made by patients.

.5 Teaching physicians who provide direct patient care may be approved for participation provided that salaries paid by hospitals or other institutions do not include a component for treatment services.

* * *

A-203. *Covered Services*

A covered service is a service for which payment can be made by the Department. Covered are those reasonably necessary medical and remedial services which are recognized as standard medical care required because of illness, disability, infirmity, or impairment, and which are necessary for immediate health and well-being.

Any question a physician may have about coverage of a particular service is to be directed to the Department prior to provision of the service.

A-204. *Services Not Covered*

Services for which medical necessity is not clearly established are not covered in the Medical Assistance Program. Additionally, the following services are specifically excluded from coverage and payment cannot be made by the Department for the provision of these services.

a. Preventive services, other than those 1) included in the Medichek Program for children through age 20 or; 2) required for school attendance.
b. Routine physical examinations.
c. Examinations required for the determination of disability or incapacity or for entrance into educational or vocational programs (Local Public

Aid offices may request that such examinations be provided with payment authorized from non-medical funds. Physicians are to follow specific billing instructions given when such a request is made.)

d. Abortion except where necessary for the preservation of the life of the expectant mother and "therapeutic" abortions, "therapeutic" being defined as follows: "medically necessary or medically indicated according to the professional medical judgment of a licensed physician in Illinois, exercised in light of all factors affecting a woman's health."

e. Experimental medical or surgical services.

f. Acupuncture.

g. Investigational and research oriented procedures.

h. Artificial insemination.

i. Transsexual surgery.

j. Services prohibited by Illinois or Federal statute.

k. Services provided in Federal or State institutions.

l. Medical care provided by mail or telephone.

m. Unkept Appointements.

n. Autopsy examinations.

o. Preparations of routine records, forms and reports.

p. Subsequent treatment for veneral disease, when such services are available through State and/or local health agencies.

q Vistis with persons other than a recipient, such as family members or group care facility staff.

r. Diagnostic and/or therapeutic procedures related to primary infertility/sterility.

s. Cosmetic procedures, medical or surgical, where projected results do not relieve a physical or functional handicap.

A-205 *Service Limitations and Requirements*

The following services are covered in the Medical Assistance Program only when provided in accordance with the limitations and requirements specified.

A-205.1 Termination of Pregnancy—Induced Abortions

An induced abortion is a covered service:

(a) when it is performed prior to fetal viability, and a licensed physician in Illinois certifies in writing that the procedure is "medically necessary". A "medically necessary" abortion is an abortion which is necessary for the preservation of the life or the physical or mental health of a woman seeking such treatment, in the professional judgment of a licensed physician in Illinois, exercised in light of all factors relevant to her health. "Fetal viability" means the point during pregnancy at which, in the professional judgment of a licensed physician in Illinois, a fetus is potentially able to live outside the mother's womb, albeit with artificial aid, such that there is a potentiality for meaningful life, not merely momentary survival; OR,

(b) regardless of whether the abortion is performed prior to or after fetal viability, if it is certified in writing:

(i) by a licensed physician in Illinois, that (s)he has determined that the life of the mother would be endangered if the fetus were carried to term; OR,

(ii) by two licensed physicians in Illinois that they have determined that severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term; OR,

(iii) that the abortion is necessary for a victim of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or

public health service. (A pregnant woman under 18 is considered to have been the victim of rape, even if she was not forced to have sexual relations.) Note that the required report must be made within 60 days of the incident and must show the name and address of the victim and the date of the incident. It also must show the name, address and signature of the person making the report and the date of the report.

To receive payment for abortions as described in the preceding paragraphs, Form DPA 1862, Abortion Certification (Revised 5-79) must be completed and submitted with the billing statement. (See Appendix A-7).

As appropriate, copies of the Abortion Certification are to be made available to the hospital to submit with the Form DPA 117, Inpatient Invoice, and to the anasthesiologist to submit with the Form DPA 132, Physician's Statement of Services Rendered.

A supply of Forms DPA 1862 may be obtained by writing Illinois Department of Public Aid, Post Office Box 4034, Springfield, Illinois 62708.

PROCEDURE: When billing for an induced abortion covered by the program under paragraph (a) above, the physician is to use the appropriate procedure code from the *Current Procedural Terminology, Second Edition.* Abortions billed as meeting the criteria in paragraph (b) above should be coded according to the following codes, identifying the reason why the procedure was necessary.

Code 59730—*Mother's Life Endangered*

The professional judgment of the physician that the life of the mother would be endangered if the fetus were carried to term.

Code 59740—*Severe and Long Lasting Health Damage*

The professional judgment of two physicians that severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term.

Code 59750—*Rape or Incest*

One all-inclusive charge is to be made for the total service provided.

A-205.2 Sterilization

Therapeutic sterilization is a covered service. A therapeutic sterilization is defined as one which either is a necessary part of the treatment of an existing illness or is medically indicated as an accompaniment of an operation on the female genitourinary tract. For purposes of this definition mental incapacity is not considered an illness or injury.

PROCEDURE: Billing statements for all therapeutic procedures which result in sterilization must indicate clearly under "Diagnosis" the therapeutic nature of the procedure. Bills on which the therapeutic intent is unclear will be returned.

Non-therapeutic sterilization is a covered service only for recipients age 21 or older, and only when mutually agreed upon by the recipient and the physician. Before proceeding to perform a sterilization, the physician must obtain the written informed consent of the recipient and advise him of his right to withdraw consent any time prior to the operation, which may be performed no sooner than 72 hours following the giving of the informed consent.

Consent must be obtained in a language understandable to the individual upon whom the procedure is to be performed.

PROCEDURE: When a recipient requests a non-therapeutic sterilization, the physician is to explain thoroughly the content of Form DPA 2189, Consent for Non-Therapeutic Sterilization (see Appendix A-6), to the recipient in the presence of an auditor-witness, designated by the recipient. This informed consent form must be signed by the physician who is to perform the procedure, the individual who is to be sterilized and the auditor-witness.

The signed Form DPA 2189 is to be attached to the physician's billing statement when charges are made for a non-therapeutic sterilization.

When a non-therapeutic sterilization is performed in a hospital by a salaried hospital staff physician, the signed Form DPA 2189 is to be attached to the hospital billing statement.

A-205.3 End Stage Renal Disease Treatment

End stage renal disease treatment—chronic hemodialysis and kidney transplantation— is a covered service only for those recipients who have been determined medically eligible for such treatment by the Illinois Department of Public Health. For recipient-patients who require end stage renal disease treatment, the physician is to submit a medical report and treatment recommendation to:

Illinois Department of Public Health
Bureau of Personal and Community Health
Renal Dialysis Program
535 West Jefferson Street
Springfield, Illinois 62761

If determined medically eligible for treatment, the recipient will be referred to a Medicare certified facility for end stage renal disease treatment. Professional staff in the facility will have responsibility for management of the treatment program and will determine the appropriate type of services needed at any time, i.e., inpatient hospitalization, outpatient or home dialysis, or kidney transplantation.

Facilities are responsible for submitting charges for outpatient and home dialysis services. Such charges are all inclusive and no additional professional charges are to be made.

Physicians may submit charges to the Department for peritoneal dialysis and other services provided during a period of inpatient hospitalization. The amount paid for shunt insertions cannot exceed the Medicare approved charge.

A-205.4 By-Pass Surgery for Morbid Obesity

This type of surgery is a covered service only with prior approval of the Department. Approval is given only in those cases in which obesity is determined to be exogenous in nature with the recipient having had the benefit of other forms of therapy (dietary, etc.) with no success, and after procedures have been performed to rule out endocrine disorders. The responsibility for the determination of cases in which these criteria are met rests with the Department.

PROCEDURE: A physician must request prior approval to do by-pass surgery from:

Illinois Department of Public Aid
Post Office Box 4035
Springfield, Illinois 62708

The physician will be advised to the specific information required for consideration to be given to his request.

If charges are submitted without prior approval consideration will not be given to payment.

A-205.5 Psychiatric Services

Treatment

Psychiatric treatment services are not covered services for recipients of General Assistance or Aid to the Medically Indigent (Categories 07 and 97).

The psychiatric treatment program of the Department is coordinated by the Department of Mental Health and Developmental Disabilities (DMHDD). A physician who desires to provide psychiatric care and services to recipients must be enrolled as an approved provider with that Department. Each individual recipient's treatment program is subject to the limitations established by the DMHDD and must be approved by the DMHDD Regional Director prior to the provision of services.

PROCEDURE: Physicians are to contact the DMHDD Regional Director (see General Appendix 4) for enrollment information, program requirements, and procedures for securing approval.

Subsequent to the provision of approved services physicians are to submit charges to the DMHDD Regional Office on forms specifically designated by that Department. After review and approval, bills will be forwarded to the Department of Public Aid for payment.

Consultations

Neither prior approval nor enrollment with the Department of Mental Health and Developmental Disabilities is required for the provision of a psychiatric consultation to determine the need for psychiatric care. However, any services provided subsequent to the initial consultation are subject to the requirements indicated above.

PROCEDURE: If the consulting physician is approved by the DMHDD for the provision of psychiatric services, charges for the consultation are to be submitted to that Department.

If the physician is not enrolled with the DMHDD, policy and procedure in Topic A-227 apply.

A-206. *Record Requirements*

Physicians must maintain an office medical record for each recipient-patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the specific physicians rendering service.

Basically, the record is to include the essential details of the recipient's health condition and of each service provided. All entries must be dated and legible.

Minimal record requirements satisfying Department standards for the various types of office visits are to be found in Topic A-220.

For recipients who are hospitalized or in a long term care facility, the primary medical record indicating the recipient's health condition and treatments and services ordered and provided during the period of hospitalization or institutionalization may be maintained as a part of the hospital or facility chart; however, an abstract of the hospital or facility record including diagnosis, treatment program, and recommendations, is to be maintained by the physician as an office record to show continuity of care.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, physicians should be aware that the medical records are a key document for post-audit of payments. In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped.

The Department's requirements on retention of records as stated in Item 11, Topic 111 in Section I, Chapter 100 are applicable to x-ray and similar records of a film-like nature. The requirements are not intended to replace professional judgment as to the length of time records are retained nor do they constitute a standard for legal purposes. The physician may choose to retain records beyond the Department's required period.

The Department has no objections to the microfilming of x-rays when it is done in compliance with applicable state laws.

A-210. PHARMACY ITEMS

Pharmacy items which are determined by the physician to be essential for the accepted treatment of a recipient's presenting symptoms and diagnosis are covered items for which payment can be made by the Department, when they are prescribed or dispensed in accordance with the following requirements and limitations.

The recipient's medical record in the physician's office is to contain entries regarding all drugs, medications, and medical supplies which are prescribed or dispensed, and the patient's response to the treatment.

A-211. *Allowable Items*

Pharmacy items, both prescription and over-the-counter items, which are covered in the Medical Assistance Program are listed in the Department Drug Manual and supplements thereto (see Section IV). Any item in the Drug Manual which is not excluded or limited (see Topic A-212) may be prescribed or dispensed in accordance with specified policy and procedure.

A-211.1 Drug Manual

The Drug Manual consists of the summary listing of the general categories of products which are included in the Medical Assistance program followed by the alphabetical listing, by either generic or trade name, of products included. Each product or general category listing is assigned a specific eight-digit item number.

* * *

A-212. *Exclusions and Limitations*

A-212.1 Exclusions

Pharmacy items which may not be prescribed or dispensed, with payment made by the Department are:

- Items not included in the Drug Manual (except for "Special Approval" items)
- Anorectic drugs or combinations including such drugs
- Biologicals and drugs available without charge from the Illinois Department of Public Health or other agencies (see Appendix A-9)
- Any vaccine, drug, or serum which is provided primarily for preventive purposes; e.g., influenza vaccine

- Vitamin B12 or liver extract except for patients with macrocytic anemia, e.g. pernicious anemia, the diagnosis of which is established on the basis of hematological studies
- Injectable drugs, when equally effective oral preparations are available
- Items such as dental products, hair products, facial tissues, infant disposable diapers, sanitary pads, tampons, soap or other personal hygiene products, articles of clothing or cosmetics of any type, proprietary food supplements or substitutes, sugar or salt substitutes, or household products
- Infant formula, except for infant requiring a non-milk base product because of an allergic reaction to the usual infant products

A-212.2 Limitations

Medical Supplies

Medical supplies are considered to be those items which are not durable or reusable as opposed to sick room needs and medical equipment items (see Topic A-212.3).

The provision of *medical supplies* is limited to those items that are required to be used by a recipient in the following of a treatment plan prescribed by the physician for a specific medical condition. Medical supplies are not to be prescribed only for a recipient's personal convenience.

Home Medicine Chest Items

Pharmacy items generally considered to be *home medicine chest items* may be prescribed only when an individual recipient's need for a specific item is extended or the item is required to be used in large quantities for a specific therapeutic reason. Such items include, but are not limited to: aspirin, cough medicine, throat lozenges, laxatives, Vaseline, gauze, adhesive tape, rubbing alcohol, etc.

Group Care Restricted Items

Pharmacy items identified in the Drug Manual as *Group Care Restricted Items* may not be prescribed for recipients living in licensed long term care facilities. Payment to the facility includes payment for the provision of such items.

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A-220. OFFICE SERVICES

Medical and surgical services which are essential for the diagnosis and/or treatment of a specific illness, symptom, or injury are covered when provided by a physician or by his office staff in his office under his direct supervision.

All office services for which charges are made must be documented in the recipient's office medical record.

Six types of office visits are recognized by the Department. Each visit for which a charge is made is to be correctly identified by the physician by use of the designated procedure code. Statements submitted with any other office visit procedure code entered are subject to return to the physician for correction.

1) *Initial Visit, New Patient*—The first visit of a patient whom the physician (or any other physician in the same group or office) has not seen before. The visit includes a limited history, a limited physical examination to the extent necessary to arrive at a provisional diagnosis, and a medical evaluation in response to presenting complaints and symptoms. Treatment is initiated and medical advice and direction given.

This type of visit is allowed *only one time* by a physician for an individual patient. In partnership or group practices, it is allowed only one time collectively for all physicians in the group regardless of the number of physicians in the group who eventually may see the recipient.

Medical Record Documentation Required—In addition to the symptoms and complaints, a limited past history; a statement of onset and course of the present condition; the physical examination findings; the laboratory and x-ray procedures ordered and their results; the provisional diagnosis; treatment given or recommended; and follow-up advice given should be listed as outlined for a comprehensive diagnostic visit.

PROCEDURE: Procedure Code *90010* is to be used to identify charges for this type visit.

2) *Routine Visit*—The most common type visit. Return visit of an established patient for examination and treatment by the physician of new complaints and symptoms, or for re-check by the physician of the previous condition and response to continuing treatment.

Medical Record Documentation Required—Symptoms or complaints (or changes therein); the onset, duration, and course of illness; history of past similar conditions and past individual history, as pertinent (allergies, etc.); physical examination findings relating to the affected area; the diagnostic procedures ordered and their results; provisional diagnosis; treatment given or recommended and advice given should be listed as outlined for a comprehensive diagnostic visit.

PROCEDURE: Procedure Code *90040* is to be used to identify charges for this type visit.

3) *Comprehensive Diagnostic Visit*—Because of the time element involved and the complexity of the examination, this is the least common type of office examination. Includes complete personal, family, allergy, and immunization history, thorough systems review and physical examination, medical evaluation and diagnosis by physician, discussion of condition with patient, initiation of treatment program, immediate and projected, and the giving of medical advice and direction to the recipient and family, as appropriate.

Medical Record Documentation Required—

Presenting symptoms and complaints
Family history (mother, father, etc.)
Individual past history
- illnesses, surgery, accidents, etc.
- allergies, sensitivities
- immunizations
- psychiatric conditions
- habits—smoking, alcohol, drugs, etc.
- weight gains or losses

Onset and course of present illness, including previous episodes
Review of systems, including past conditions
Physical examination findings—including unrelated abnormal findings as well as those pertinent to present illness
Investigative procedures such as laboratory and x-ray examinations—listing of all diagnostic procedures ordered, when, where and reports of findings of each
Copy of any consultation reports requested
Provisional diagnosis or problem oriented impression, including other possible diagnoses, if appropriate
Treatment record—injections given (what, amount, etc.); medications prescribed or dispensed (what, amount, dosage, etc.); any other medical treatment given; surgical treatment given or recommended
Recommendations for follow-up or subsequent treatment
Other details and specifics as the condition of the recipient may require

PROCEDURE: Procedure Code *90020* is to be used to identify charges for this type visit.

4) *Intermediate Visit*—A visit by an established patient at which time a complete re-evaluation and physical examination *are necessary* for diagnostic purposes and are done by the physician. Includes initiation of treatment and the giving of medical advice and direction.

This type of visit is not routine and is considered necessary only when changes in the presenting symptoms and complaints are such that an additional in-depth re-evaluation is required to confirm diagnosis and treatment program.

Medical Record Documentation Required—Of prime importance is the description of new complaints and symptoms (or changes in previous ones), or the lack of anticipated improvement which necessitates the need for a complete evaluation. Good or adverse results of treatment and new or changed physical findings since previous visit(s) should be listed. New laboratory or x-ray procedures and their results, additional or secondary diagnoses and revisions or new modes of treatment are to be recorded. Intended follow-up policy should also be shown.

PROCEDURE: Procedure Code *90070* is to be used to identify charges for this type visit.

5) *Minimal Visit*—Brief return visit not necessitating evaluation and examination. To be used, for example, when injections are given or dressings applied, or when only progress and response to treatment and/or medications is checked.

Medical Record Documentation Required—The record must show *what* was done and by whom. In the event of any adverse or questionable progress, a notation should be made. Advice for future treatment is to be listed.

PROCEDURE: Procedure Code *90030* is to be used to identify charges for this type visit.

6) *Referral (Transferred Patient)*—A referral applies to services provided a recipient-patient who is sent by one physician to another for diagnosis and/or treatment. In

reality this is a transfer of a patient, the receiving physician most frequently being a specialist or in a different field of practice than the referring physician.

A patient acquired in such a manner is considered to be a transferred patient and the visit classified the same as any first visit to that physician—initial visit, new patient. Coding should be consistent with complexity of condition.

Visits of referred (transferred) patients are *not* considered, and may not be billed as, consultations. (See Topic A-227 for definition and services of consultants.)

PROCEDURE: Procedure code *90010* is to be used for the great majority of initial visits of referred patients. In unusual and exceptional cases of great complexity, procedure code *90020* may be used if warranted. While no written report of the examination and findings is required to be sent to the referring physician, his name must be entered on Form DPA 132 when submitted for payment.

At the time of an office visit, the physician may provide medical and/or surgical procedures. When a procedure is performed, a charge may be made for either the visit or the procedure, but not for both.

A charge may be made for a physical examination provided to a child in accordance with the requirement of the Illinois School Code for such an examination for all pupils entering kindergarten or first grade, fifth, and ninth grades, only if the child is not receiving scheduled Medichek services. The Medichek examinations at ages 5, 6, 10 and 14 meet school examination requirements and, therefore, are not to be duplicated.

PROCEDURE: Procedure code *90034* is to be entered on Form DPA 132 to identify the service charge and the school grade level for which the examination was given is to be included.

When a charge is made for a school physical examination, the recipient child's medical record in the physician's office is to include a report of the examination findings and clearly indicate the child's non-participation in the Medichek Program.

A-221. *Medical Diagnostic and Treatment Services*

A-221.1 Laboratory Tests

Only those laboratory tests and examinations which are essential for diagnosis and control are covered. Laboratory tests must be consistent with good medical practice.

Routine screening tests are not covered, except as specified for provision under the Medichek Program.

A physician may charge only for those tests done in his office, by his own staff, using his equipment and supplies.

Charges may not be made, nor is a physician to make referral, for laboratory tests which are provided by the Illinois Department of Public Health without charge (see Appendix A-10); except that, the physician may either do in his office laboratory and make charges, or make referral, for essential throat and urine cultures in instances in which use of the Department of Public Health laboratory would result in delay in diagnosis and treatment.

PROCEDURE: Charges for throat and urine cultures done in the physician's office are to be coded on Form DPA 132 as follows;

Code *87081* Culture (throat) Screening for organism
Code *87082* Culture (urine) Screening for organism
Code *87091* Culture (throat) Definitive for organism
Code *87092* Culture (urine) Definitive for organism

Charges may not be made for sensitivity studies when a culture shows no growth or when a growth is identified as beta hemalytic streptococcus.

A central laboratory serving physicians in group practice is considered a physician's office laboratory, unless the laboratory is a Medicare certified independent laboratory.

When laboratory tests only are done, an office visit charge may not be made.

PROCEDURE: Charges for office laboratory tests are to be submitted on Form DPA 132. Common laboratory tests are precoded in Part B, Section 2.2. A test which is not precoded is to be shown in Section 3, with the date and place of service indicated. If any one test is done more than one time in the month, a separate entry is necessary.

Profile or panel tests are to be done only when essential and must be so identified.

PROCEDURE: When charges are made for an SMA 12, procedure code 89370 is to be used in Section 3. It is not necessary to list the individual test included in this panel.

Procedure code 89371, lab profile tests, precoded in Part B Section 2.2 is to be used for all other profile tests. *The name of each test in the panel is to be specified in Section 3.*

For necessary laboratory tests not done in the physician's office, the physician may make *written* referral to 1) the outpatient department of a participating hospital, 2) a pathologist in private practice, or 3) a Medicare certified independent laboratory. When referral is made, the physician must specify the tests ordered. Blanket, "rule out", or open-ended requests are not allowed. The physician must use discretion in ordering only those laboratory tests necessary and pertinent to the condition which he is treating. No payment will be made to a laboratory for tests done which are not consistent with the diagnosis.

The physician may not charge for making referral, for obtaining or sending of a specimen for analysis, or for tests ordered.

In each instance, the provider of services is to make charges direct to the Department and provide a written report of test results to the physician for filing in the recipient's medical record.

When referral is made to an independent laboratory, the physician must include his AMA Medical Education number and the recipient's diagnosis or presenting symptoms which indicate the need for the specific tests ordered.

A pathologist in private practice may charge for the specific tests and examinations provided, however, an additional office visit charge may not be made. If the pathologist has his office laboratory certified by Medicare as an independent laboratory, independent laboratory policy and procedure apply.

A hospital based pathologist may submit charges to the Department for his professional services in connection with referred laboratory services only if his contractual agreement with the hospital provides for separation of charges.

PROCEDURE: Charges for the professional component of laboratory services are to be submitted on Form DPA 132 with appropriate procedure codes. The place of service is to be shown as "OH", Outpatient Hospital.

A-221.2 X-Ray Services

X-ray services are covered when essential for the diagnosis and treatment of disease or injury. Routine screening x-rays are not covered.

Ultrasound imaging, scanning, echograms or sonograms are covered only when essential and then only in unusual circumstances, such as a variation from the normal or from normal progress of a condition which would be detectable by such a procedure. Routine screening or surveys are not allowed, nor are "rule out" examinations unless a specific differential problem exists.

PROCEDURE: Procedure codes 95950 through 95982 are to be used as appropriate. The procedure code, date, and place of service ("0") are to be entered in Section 3 of Form DPA 132. The physician must include a provisional diagnosis or sufficient explanation of the abnormal condition for which the service was provided.

When a charge is made for ultrasound examinations, an additional charge may not be made for radiographic examinations of the same area or systems unless adequate justification is given for both procedures.

A physician may charge only for x-ray examinations done in his own office, by his own staff, using his equipment and supplies.

A central x-ray department serving physicians in group practice is considered the physician's office.

PROCEDURE: Certain x-ray examinations are precoded in Part B, Section 2.3 of Form DPA 132. If a specific type x-ray is not precoded, it is to be reported in Section 3. The date and place of service (indicated as "O" for Office) are to be entered for each x-ray for which a charge is made.

When x-rays only are provided at the time of an office visit, an office visit charge may not be made.

When it is necessary for a physician to read comparison x-rays, and it is his usual and customary practice to make an additional charge for this service, procedure code *76490* is to be used to identify the charge.

The physician may make written referral, for a recipient to have x-ray examinations or therapy, to a hospital outpatient department or to a radiologist in private practice. The physician may not charge for the referral. The provider of the x-ray services is to make charges direct to the Department. The charge for x-rays includes the provision of a written report to the referring physician, which he is to file in the recipient's medical record.

A radiologist in private practice may charge for the specific x-ray examinations or therapy provided. Additional office visit charges may not be made.

PROCEDURE: When therapy treatments are provided, the appropriate procedure code, date, and place of service ("O") are to be entered in Section 3 of Form DPA 132 for each treatment given.

A hospital based radiologist may submit charges to the Department for his professional services in connection with referred x-ray services if his contractual agreement with the hospital provides for separation of charges and the hospital does not bill.

PROCEDURE: Charges for the professional component of x-ray services are to be submitted on Form DPA 132 with the appropriate procedure codes and date(s). The place of service is to be shown as "OH", Outpatient Hospital. When x-ray therapy is given, the date, procedure code, and place of service ("OH") are to be entered in Section 3 for each treatment.

If a charge is made for the use of portable x-ray equipment, the use of such equipment requires prior approval of the local Public Aid office.

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A-222. *Surgical Services*

Essential minor surgical procedures which are customarily done in the physician's office are covered services. When charges are made for a surgical procedure, an additional charge may not be made for an office visit.

PROCEDURE: The procedure code for the specific surgical procedure is to be entered. A description of the procedure, e.g. size of lesion, number of sutures, removal procedure, etc., is to be provided.

The procedure code for office cryosurgery without biopsy and without dilation and curettage is 57513.

A charge may not be made for post-operative office visits and treatment following major surgery for a minimum of 30 days.

A-222.1 Anesthesia

When an office surgical procedure requires the administration of local anesthesia, no additional charge may be made for the anesthesia agent or for the administration, as both are considered a part of the operative procedure.

A-222.2 Dressings

For customary surgical dressings no charges may be made in addition to office visit or procedure charges. For dressings which are unusually expensive or required in large amounts, e.g. medicated dressings, charges may be made if substantiating clinical data is submitted.

A-223. *Burn Treatment*

Charges may be made for surgical debridement and dressings for burns, when substantiating information is submitted. No additional charge may be made for the office visit.

PROCEDURE: Procedure codes *16000* through *16030* are to be used. The location of the debridement and the size, in centimeters, of the area debrided are to be included. Also, the cost to the physician of the burn dressings is to be included.

A-224. *Eye Care*

Ophthalmologists and other physicians skilled in treatment of diseases of the eye and its appendages may provide eye care and treatment. Services which may be provided include: 1) those required to determine the presence of disease and whether treatment is indicated; 2) essential medical and surgical treatment; 3) the determination of the refractive state of the eyes; and 4) the prescribing and provision of glasses and other ophthalmic supplies.

A-224.1 Medical and Surgical Diagnostic and Treatment Services

Provisions of Topics A-221, A-222, and A-240 regarding office and hospital services apply when eye care is provided.

Diagnostic ophthalmological procedures which may be provided are listed in Appendix A-11. The provision of any other procedure requires prior approval.

PROCEDURE: The appropriate procedure code designated for the specific procedure is to be entered on Form DPA 132. When prior approval is required, a written request is to be submitted by the physician, with pertinent medical information, to Illinois Department of Public Aid, Post Office Box 4035, Springfield, Illinois 62708. Notification of approval or disapproval of the request will be sent to the physician. If the request is approved, a copy of the approval notice is to be attached to the Form DPA 132 used for billing.

Muscle surgery may be provided in a case in which improvement in vision or binocular function is the objective. Muscle surgery for cosmetic purposes may be provided for children having a deviation of 20 or more prism diopters for distance or near fixation. Muscle surgery for cosmetic reasons for adults requires prior approval.

PROCEDURE: A written request for approval to provide muscle surgery for an adult recipient is to be submitted by the physician to Illinois Department of Public Aid, Post Office Box 4035, Springfield, Illinois 62708. The request is to include pertinent medical information which substantiates the need for the surgery. If the request is approved, the physician is to attach a copy of the approval notice to the Form DPA 132 used for billing.

A-224.2 Determination of the Refractive State of the Eyes

This service is not covered for recipients of General Assistance or Aid to the Medically Indigent (Categories 07 and 97), unless specifically requested by the Department in individual cases. In such instances, the recipient will have written authorization from the Department to present to the physician.

Except in unusual circumstances, no more than one refraction per year is allowed.

When a charge is made for a refraction, an additional charge may not be made for the prescription for glasses, if needed, or for the re-examination to check the glasses provided.

PROCEDURE: If the only service provided in a given month is a simple refraction and glasses are dispensed (see Topic A-224.3), Form 136 is to be used as the billing statement for both the refraction and the glasses. (See Appendix A-2 and A-2a.) If a simple refraction is the only service and glasses are not dispensed by the physician, Form DPA 132 is to be used and the charges for the refraction listed with procedure code 92034.

A-224.3 Provision of Glasses and Ophthalmic Supplies

This service is not covered for recipients of General Assistance or Aid to the Medically Indigent (Categories 07 and 97), unless specifically requested by the Department in individual cases. In such instances, the recipient will have written authorization from the Department to present to the physician.

A physician may dispense glasses and other ophthalmic supplies or he may give the necessary prescription to the recipient to take to the optician of his choice.

Charges are to be made for glasses and other supplies, exclusive of frames, at a cost plus 15%. Payment will be made as charged, if reasonable.

PROCEDURE: If the physician dispenses, Form DPA 136 is to be used to submit charges to the Department. When artificial eyes or prosthetic lenses for aphakic patients who are eligible for Medicare benefits are dispensed, Form DPA 136 is not to be submitted to the Department until the Explanation of Benefits is received from the Medicare intermediary. Form DPA 136 is then to be attached to a copy of the SSA 1490 and a copy of the Explanation of Benefits and submitted. (See Chapter 100, Topic 122.1.)

If the physician does not dispense, he is to write the prescription on Form DPA 136 to be given to the optician in duplicate. The optician will subsequently use the form for submittal of his charges.

The physician is to dispense or prescribe in accordance with the following requirements.

A-224.31 Lenses

Initial lenses may be provided only when the total correction in one eye is at least 0.75 diopters.

A subsequent change of lenses may be provided only when the difference between the previous prescription and the new prescription is at least 0.75 diopters in one eye.

Lenses must be impact resistant.

Lenses must be first quality as defined by the American Standards Association and must meet Federal regulations.

Glass lenses must be furnished without defects or imperfections, such as chips, bubbles, or scratches.

A-224.32 Frames

New frames may be provided through the Medical Assistance Program when necessary. They are not to be provided based only on a recipient's preference for a change in style, color, etc.

A-224.33 Repairs and Replacement

Frames are to be repaired and parts replaced when possible rather than new frames dispensed. Whenever possible, old frames are to be used when a lens needs to be replaced or when new lenses are prescribed. When a frame is not repairable and a new frame is needed, old lenses are to be used unless a change in prescription is required.

A-224.34 Dispensing Fee

A charge may be made for dispensing if it is the physician's customary practice to make such a charge. The charge covers the glasses case and any necessary mailing costs.

A-224.35 Prior Authorization Requirements

The following articles may be provided only with prior authorization of the Department:

- Lenses which do not meet stated specifications. (See Topic A-224.31.)
- Tinted or plastic lenses
- Spare glasses
- Trifocals (replacement does not require prior authorization)
- Special ophthalmic supplies such as contact lenses, subnormal visual corrective devices, or custom-made artificial eyes

PROCEDURE: The physician is to request prior approval to dispense or prescribe by submitting Form DPA 136, Complete except for signature and date of service, in duplicate, to

Illinois Department of Public Aid
Bureau of Special Medical Operations
2036 South Michigan Avenue—Second Floor
Chicago, Illinois 60616

An explanation of the need for the specific item is to be given. Approval or disapproval of the request will be entered on the forms and both copies returned to the physician.

If the request is approved and the physician dispenses, he is to use the original copy of the form, on which approval is indicated, as his billing statement after the items have been provided.

If the request is approved and the physician does not dispense, both copies which have been returned to him, with approval indicated, are to be sued as his prescription and given to the optician for filling and subsequent billing.

A-225. *Medichek Services*

These services are not covered for recipients of General Assistance or Aid to the Medically Indigent (Categories 07 and 97).

The Medichek Program provides for children from birth through age 20 to receive periodic screening and diagnostic services to detect or prevent physicial and mental defects. Allowable services are:

1) scheduled medical examinations beginning at 6 weeks of age, and
2) immunizations.

To provide Medichek services, a physician must be enrolled with the Illinois Department of Public Health. All billing statements for Medichek services are submitted to that Department.

PROCEDURE: For enrollment information, program explanation, and specific billing procedures and forms for Medichek services, the physician is to contact the Medichek coordinator in the local Public Aid Office

If as a result of Medichek screening services, a condition is detected which requires further diagnostic procedures and/or treatment, such services may be provided if they are covered services under the Medical Assistance Program. Charges for these services are to be submitted to the Department.

PROCEDURE: Form DPA 132 is to be used for billing for treatment provided as the result of Medichek screening services. Charges for the Medichek services are not to be included.

A-226. *Family Planning Services*

Services and supplies for the purpose of family planning are covered regardless of age, sex, or marital status. The physician may provide a physical examination, including breast examination, pelvic examination, and Pap smear. Contraceptive supplies may be dispensed or prescribed or ordered.

PROCEDURE: One all-inclusive charge is to be made for the office visit and physician's services provided for family planning purposes.

When an intrauterine device is inserted, procedure code 58300 is to be used. If a charge is made for the device, procedure code 99200 is also to be entered along with information as to type and cost to the physician.

When an intrauterine device is not inserted, procedure code 90041 is to be entered.

An additional charge may be made for a Pap smear *only* if the physician does the laboratory examination in his own office laboratory.

A-227. *Consultations*

A physician may request the service of another physician when essential for diagnosis and/or treatment recommendations.

The Department considers a consultation to be a deliberation of two or more physicians with respect to the diagnosis and/or treatment in any particular illness or condition involving a recipient, with the consultant *not* assuming direct care of the recipient. If the consultant does assume direct and daily care, he is then considered to be the attending physician in lieu of the physician formerly providing such care.

In making charges for a consultation, a written report is to be made a part of the recipient's record in both the consulting and requesting physician's records.

PROCEDURE: A procedure code of 90600 through 90630, as appropriate, is to be used to identify a charge for a consultation. (NOTE: These codes are *not* to be used for *Referrals* as defined in Topic A-220.)

Information must be entered on Form DPA 132 submitted by the consultant that he performed the service as a consultant rather than as the attending physician. The name of the physician who requested the consultation must also be entered on the billing form.

If, subsequent to a consultation, the physician consultant provides direct or continued care to the recipient, all subsequent services will be considered as provided in the role of attending physician. The consultation will then be considered to be the initial comprehensive visit and subsequent charges for this service may not be made.

A presurgical examination by the operating surgeon is considered an essential element of the surgical procedure and is not reimbursable as a consultation.

Charges may not be made to the Department for a consultation, a medical opinion or a report which is requested by another party or agency.

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A-242. *Inpatient Services*

A physician may admit a recipient for essential inpatient hospital services in connection with covered treatment of an illness or injury.

A-242.1 Utilization Review

The medical need for hospital admission and the length of the hospitalization are monitored and controlled by:

- The Hospital Admission and Surveillance Program (HASP)

or

- The Hospital Utilization Review Committee (URC)

or

- The Department of Mental Health and Developmental Disabilities (DMHDD)

HASP controls hospitalization of recipients not eligible for Medicare benefits. The hospital URC controls hospitalization of the recipients eligible for Medicare benefits. The DMHDD controls hospitalization of recipients admitted for inpatient psychiatric services.

Limitations are placed on length of stay according to diagnosis and specific need of the individual recipient for hospital care.

The physician will be notified by the representatives of the appropriate monitoring authority when a determination has been made that continued inpatient hospitalization is not essential. If the recipient is not discharged within 72 hours after such a determination is made, payment by the Department for any additional period of hospitalization will cease. Additionally, payment for physicians' services provided during the unauthorized period of hospitalization will be denied.

PROCEDURE: If a physician questions a determination that continued hospitalization is non-essential, he should contact the Chairman of the URC, the HASP Coordinator for the hospital, or the DMHDD Regional Office, as appropriate.

If the physician desires the assistance of the local Public Aid caseworker in making arrangements for care after discharge, he should contact the local Public Aid office.

A-242.2 Surgery

Covered surgical procedures which are medically necessary are allowable.

The charge made for an operative procedure includes complete post-operative care for a minimum period of 30 days, including customary wound dressings.

When a charge for surgery is greater than the physician's usual and customary fee for the procedure, based on the operation being seriously complicated by factors not usually present, the physician is to submit clinical data adequate to support the claim.

When multiple surgical procedures are performed through the same incision, payment will be based on charges for the major procedure.

For material of significant value such as orthopedic pins and nails, which are supplied by the physician, payment will be made based on cost to the physician.

PROCEDURE: The appropriate procedure code for the specific surgical procedure is to be entered on Form DPA 132. When higher than usual charges are made for a complicated procedure, complete clinical information is to be included. The procedure code for the major procedure is to be used when multiple procedures are performed. When charges are made for materials supplied by the physician, the description of the material and cost to him are to be specified and procedure code 99200 entered.

When cryosurgery is done with extensive conization and with biopsy and dilation and curettage, the procedure code to use is 57515.

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Chapter H-200

Hospital Services

The Illinois Medical Assistance Program provides payment for hospital services in the following categories of service for eligible Public Aid recipients:

- Inpatient Hospital Services (General)
- Inpatient Hospital Services (Psychiatric)
- Inpatient Hospital Services (Physical Rehabilitation)
- Inpatient Hospital Services (End Stage Renal Disease)
- Outpatient Hospital Services (General)
- Outpatient Hospital Services (End Stage Renal Disease)
- Clinic Services (General)
- Clinic Services (Psychiatric A)
- Clinic Services (Psychiatric B)
- Clinic Services (Physical Rehabilitation)
- Medichek Screening Services

For consideration to be given by the Department to payment for hospital services, the services must be provided by a participating hospital that is enrolled for the specific category of service for which charges are made and the services must be provided in full compliance with the policy and procedures contained in the various sections of this Handbook.

H-200 BASIC PROVISIONS

H-201 *Participation*

To participate in the Illinois Medical Assistance Program, a hospital must meet the requirements of Topic H-201.1. Any additional participation requirement(s) that must be met for enrollment to provide a specific category of service are specified subsequently in this chapter under the appropriate topic.

H-201.1 Requirements

The following requirements must be met by a hospital to qualify for enrollment:

1. The hospital must hold a valid license issued by the State in which the hospital is located;

2. The hospital must be certified by the Social Security Administration for participation in the Medicare Program (Title XVIII);

or

if not eligible for or subject to Medicare certification, must be accredited by the Joint Commission on the Accreditation of Hospitals;

3. The hospital must agree to accept the Department of Public Aid basis for reimbursement;

4. The hospital must enroll and sign Form DPA 1431, Hospital Agreement.

PROCEDURE: The hospital is to complete and submit:

- Form DPA 1420, Hospital Enrollment Form
- Form DPA 1431, Hospital Agreement

The required forms are to be obtained from:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708

The original copy of each form must be completed (printed in ink or typewritten), signed and dated in ink by the chief administrative officer of the hospital and returned to the above address. A copy of each completed form is to be retained by the hospital.

The hospital will be notified by the Department of approval or denial of participation.

H-201.2 Participation Approval

When participation is approved the hospital will be sent a computer-generated notification, the Provider Information Sheet, reflecting all identifying data regarding the hospital, the categories of service the hospital is enrolled to provide, the effective date of enrollment for each category, the approved reimbursement rate and the forms request information. See Appendix H-20 and H-20a for a sample of the Provider Information Sheet and related explanation.

In instances in which a hospital is enrolled to provide services in a location apart from the hospital, a separate Provider Information Sheet will be prepared for each separate location showing the unique provider number assigned. Appropriate data, as indicated above, will be listed for all categories of service that may be provided at the specific location.

H-201.3 Participation Denial

If it is necessary for any reason to deny participation, written notification will include the basis for such a determination. Within 10 days of the date of such notice, the hospital may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within 10 days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. (See Section III, General Appendix 7A, Rules for Department Actions Against Medical Vendors, and General Appendix 7B, Rules of Practice for Medical Vendor Administrative Proceedings.)

H-201.4 Provider File Maintenance

The information carried in Department files for participating providers must be maintained on a current basis. The hospital and the Department share responsibility for keeping the file updated.

H-201.41 *Hospital Responsibility*

The information contained on the Provider Information Sheet is that carried on Department files. Each time the hospital receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. Inasmuch as the Provider Information Sheet contains information to be used by the hospital in the preparation of billing statements, any inaccuracies found are to be corrected and the Department notified immediately.

PROCEDURE: The hospital is to line out erroneous information and enter corrected data in the space below the error and forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708

Any time a hospital makes a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified in the same manner as indicated in the preceding paragraph. When possible, 30 days minimum notification should be made in advance of a change in order to allow updating of Department files.

Failure of a hospital to properly notify the Department of corrections and/or changes may cause an interruption in participation and/or disrupt the normal payment process.

H-201.42 *Department Responsibility*

Whenever there is a change in enrollment status; i.e., approval is given or withdrawn for the provision of a specific category of service, an updated Provider Information Sheet will be generated indicating the change, the effective date and, if appropriate, the approved rate.

Whenever there is a change in the approved interim reimbursement rate for a hospital, an updated Provider Information Sheet will be generated indicating the new rate and the effective date.

H-202 *Reimbursement*

Reimbursement to participating hospitals is based on annual cost reconciliation information.

H-202.1 Hospitals Exempt From Submittal of Cost Information

Those out-of-state hospitals *which are exempt from submitting cost information,* because they serve few Illinois Department of Public Aid clients, are reimbursed at the same rate of reimbursement as that authorized for Title XIX recipients in the State in which the hospital is located.

H-202.2 Hospitals Required to Submit Cost Information

Cost reports are required from all Illinois hospitals and all out-of-state hospitals anticipating 200 inpatient census days of service to recipients of the Illinois Medical Assistance Program.

The Department's rate of payment to all Illinois hospitals and all out-of-state hospitals required to submit cost information is individualized by hospital and is based on reasonable costs which do not exceed the reimbursement under Title XVIII (Medicare) methods of apportionment. Costs not allowable under Title XVIII are not considered in determining rates under Title XIX (Medicaid).

The reimbursement system for these hospitals is a retrospective rate setting system with payment rates based on the hospital's latest annual cost report as filed by the hospital and desk and field audited by the Illinois Department of Public Health, Office of Health Finance. Cost analysis by that office or its authorized agent provides the Department of Public Aid with the information necessary to, 1) establish reimbursement rates for hospital services and 2) reconcile past payments with operating costs for the same fiscal period.

The approved rate and the effective date, appropriate for the category of service the hospital is enrolled to provide, are shown on the Provider Information Sheet. The rate charged by the hospital when billing the Department for services rendered to Public Aid recipients must be the appropriate rate in effect for the category of service on the date the service was provided. When a new rate is approved, an updated Provider Information Sheet will be sent to the hospital showing the new rate and the effective date.

H-202.21 *Preparation and Submittal of Cost Information*

Upon application for participation in the Medical Assistance Program, the Office of Health Finance, Illinois Department of Public Health, will supply the appropriate forms and instructions for completion of the Hospital Statement of Reimbursable Cost. Directions for maintaining a separate hospital log for both inpatient and outpatient services, reimbursed by the Department of Public Aid, will be provided by that office. The separate log for each of the two types of services should combine service information for all recipients of the following categories: 00, 90, 01, 91, 02, 92, 03, 93, 04, 94, 95, 06, 96 and 98. A separate log for General Assistance and Aid to the Medically Indigent (categories 07 and 97) must be kept for each payor (township or commission). A separate log also must be kept for Migrant Medical Program cases (category 97). Where Third Party payments equal or exceed the Department's approved rate, the hospital may elect to include or exclude these costs from the hospital's log and subsequent reconciliation.

Cost information must be submitted *annually within 90 days of the close of the hospital's fiscal year.* The Office of Health Finance will send the required forms and instructions to the hospital each year approximately ten days prior to the close of the hospital's fiscal year. The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted for review as directed by

the Office of Health Finance. If the cost information is not submitted on a timely basis, the Department of Public Aid will temporarily suspend processing of any bills from hospitals whose cost reports are delinquent. The processing of bills will resume after the cost report is received and reviewed by the Office of Health Finance.

Generally, payment rates are based on the latest annual cost report filed by the hospital; however, at the option of the hospital, an interim rate adjustment can be made no more than semi-annually based on six or more months' data from the hospital's current fiscal year. Office of Health Finance should be contacted to request an interim rate review.

Written inquiries regarding the preparation and submittal of the cost statement are to be directed to:

Illinois Department of Public Health
Office of Health Finance
525 West Jefferson Street
Springfield, Illinois 62761

Telephone inquiries are to be directed to (217) 782-6235.

H-202.22 *Reconciliation*

Annually, payment made at interim rates during the hospital's fiscal year will be reconciled to reasonable allowable costs.

At the request of the hospital, a preliminary settlement will be made within 60 days of the cost report filing date in an amount equal to 70 percent of the amount claimed by the provider or due the Department of Public Aid on the cost report as submitted (as adjusted for obvious errors or inconsistencies).

Based on a desk audit, a full reconciliation amount usually will be processed for payment to or collection from the hospital within 90 days of filing of the cost report. The reconciliation is not considered to be final, however, until a field audit has been made.

AABD, AFDC, MANG, REFUGEE/REPATRIATE PROGRAM

If payments made to the hospital during its fiscal year exceed the amount which would have been paid at the rates approved for the hospital by the Department, the excess will be credited against future obligations of the Department or refunded to the Department. If payments were less than cost, supplementary payment to the hospital will be made by the Department.

GA, AMI

If payments made to a hospital during its fiscal year exceed the amount which would have been paid at the final cost determined for the hospital by the Department, the excess will be credited against future obligations of the Department (or township or commission) or refunded to the Department (or township or commission).

MIGRANT MEDICAL PROGRAM

If payments made to the hospital during its fiscal year exceed the amount which would have been paid at the reimbursable rates approved for the hospital by the Department, the excess will be credited against future obligations of the Department or refunded to the Department.

H-203 *Covered Services*

The Medical Assistance Program provides for essential inpatient, outpatient and clinic diagnostic and treatment services that are provided to recipients by participating hospitals.

To qualify for payment, all hospital services must be provided in accordance with policy and procedure as set forth in this Handbook.

H-204 *Services Not Covered in the Medical Assistance Program*

Certain services are not covered in the scope of the Medical Assistance Program and payment cannot be made for their provision to Public Aid recipients. Such services include the following.

1. Services prohibited by Illinois or Federal statutes.

2. Services available without charge.

3. Care provided by or in Federal hospitals.

4. Care provided by a hospital located in Illinois which is not enrolled in the Medical Assistance Program.

5. Experimental medical or surgical procedures.

6. Autopsy examinations.

7. Research oriented procedures.

8. Medical or surgical transsexual treatment services.

9. Diagnostic and/or therapeutic procedures related to primary infertility/sterility.

10. Acupuncture.

11. A hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing (see Topic H-214.14 for additional clarification).

12. Abortion except when a) performed prior to fetal viability and a licensed physician in Illinois certifies in writing that the procedure is medically necessary; or b) when performed prior to or after fetal viability, it is certified in writing i) by a licensed physician in Illinois that the life of the mother would be endangered if the fetus were carried to term, or ii) by the two licensed physicians in Illinois that severe and long lasting physical health damage to the mother would result if the fetus were carried to term, or iii) that the abortion is necessary for a victim of rape or incest when the rape or incest was reported promptly to a law enforcement agency or public health service (See H-214.15).

13. Medical examinations required for the determination of eligibility for assistance. (Local Public Aid offices may request that these examinations be provided with payment from non-medical funds. Hospitals are to follow specific billing procedures given when such a request is made.)

14. Preventive services, with the exception of those provided through the Medichek Program for children through age 20 including required school examinations.

15. Artificial insemination.

16. Surgery for cosmetic purposes.

17. Non-medically necessary items and services provided for convenience of recipients and/or their families such as radios, televisions, telephone calls, meals and quarters for relatives, etc.

18. Preparation of routine records, forms and reports.

Should a hospital have a question regarding the inclusion of any other service, the Department is to be contacted at Post Office Box 4034, Springfield, Illinois 62708.

H-205 *Services Not Covered as Hospital Services*

Some services, although included in the Medical Assistance Program and under certain circumstances provided in the hospital setting or by an entity associated with the hospital, are not considered by the Department as a "hospital" category of service. (See Topics H-205.1 to H-206.)

Whenever a hospital has a question as to whether a particular service is covered, the Department is to be contacted at Post Office Box 4034, Springfield, Illinois 62708. (Telephone (217) 782-0496.)

H-205.1 Private Duty Nursing Services

Hospitals may not enroll to provide private duty nursing services.

Hospitals are expected to provide all required nursing services and, generally, persons requiring special nursing care are placed in an intensive care unit. Only in extraordinary instances in which a recipient's condition or the type of care needed requires many more hours of professional nursing service than the hospital can be expected to provide will approval of a private duty nurse, either a registered nurse or a licensed practical nurse, be considered by the Department.

Prior to making arrangements for private duty nursing services, the attending physician or the hospital at the physician's request is to contact the local Public Aid office to provide specific information regarding the need for the services in order to obtain prior approval. When private duty nursing services are approved by the local office for an individual recipient, the nurse submits charges to the Department and direct payment is made to the nurse.

H-205.2 Sitter Services

Hospitals may not enroll to provide sitter services.

Sitter services are provided only in those rare instances in which the condition of a hospitalized recipient necessitates a sitter to watch at the bedside. Consideration will be given to approval by the Department only in those unusual cases in which hospital staff, volunteers, relatives or friends of the recipient are unable to provide the services.

Prior to making arrangements for sitter services, the attending physician or the hospital at the physician's request is to contact the local Public Aid office to provide specific information regarding the need for sitter services in order to obtain prior approval. When the services are approved for an individual recipient, the person providing the services submits charges to the Department and direct payment is made to that individual.

H-205.3 Dental Services

Hospitals may not enroll to provide dental services.

When dental services are provided in the outpatient/clinic setting of a hospital, the dentist submits charges to the Department and direct payment is made to the dentist.

H-205.4 Long Term Care Services

Long term care services are not considered by the Department to be hospital services.

Hospitals, which have 1) a special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program or 2) a special unit or separate facility administratively associated with the hospital and licensed as a long term care facility, may not utilize such beds or facilities for hospital services.

If the hospital desires to receive payment for services provided to recipients utilizing these facilities, it is necessary for the hospital to apply for participation as a long term care facility.

Information regarding participation requirements and enrollment procedures for the provision of long term care services may be obtained from:

Illinois Department of Public Aid
Bureau of Group Care Services
931 East Washington Street
Springfield, Illinois 62763
Telephone (217) 782-0549

H-205.5 Pharmacy Services

The provision of pharmaceutical items and supplies to Public Aid recipients by the hospital pharmacy is not considered by the Department to be a hospital service when any pharmacy item or supply is dispensed to a recipient who is a patient in:

a) a specified bed or special hospital unit which is certified for skilled nursing facility services under the Medicare Program;

and/or

b) a special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility.

If the hospital desires to receive payment for pharmacy services provided under the specified circumstances, it is necessary for the hospital to apply for participation as a pharmacy provider.

Information regarding participation requirements and enrollment procedures for the provision of pharmacy services may be obtained from:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708
Telephone (217) 782-0496

H-205.6 Ambulance Services

The services by an ambulance service which is administratively associated with a hospital, *the cost of which is not included in the hospital's reimbursable cost report,* are not considered by the Department to be hospital services. Such an ambulance service may not bill the Department unless it is enrolled for participation as an ambulance service provider.

Information regarding application and enrollment may be obtained from:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708

H-205.7 Home Health Services

Home health services are not considered by the Department to be hospital services.

A home health agency which is administratively associated with a hospital and which is certified for participation as a home health agency in the Medicare Program may apply for participation in the provision of home health services to Public Aid recipients.

Information regarding application and enrollment of a home health agency may be obtained from:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708
Telephone (217) 782-0496

H-206 *Record Requirements*

General requirements pertaining to the maintenance and retention of records are included in Section I, Chapter 100, Topic 111(11).

Participating hospitals must comply with all Federal and State regulations that govern medical records. Department of Public Aid requirements for hospital records pertaining to specific categories of service are included in subsequent topics of this chapter.

The Department regards the maintenance of adequate medical records as essential for the delivery of quality medical care. Medical records are key documents for the audit of payments. Access to these records, by persons designated by the Agency must be permitted. In the absence of proper and complete records, payment may be withheld and/or a recoupment initiated in accordance with provisions indicated in Section I, Chapter 100, Topic 149 and Section III, General Appendix 7A and 7B.

H-210 GENERAL INPATIENT HOSPITAL SERVICES

Inpatient hospitalization is covered only when a recipient's medical need for the services on an inpatient basis is documented in accordance with established utilization review policy and procedures.

General inpatient hospital services are defined by the Department as those services ordinarily provided by licensed general hospitals, other than those identified inpatient services for which the Department has established specific participation requirements. Included in general inpatient services are medical, surgical, pediatric, orthopedic, maternity, intensive care services, etc.

Inpatient services necessary for the treatment of tuberculosis are also considered to be general inpatient services; however, payment for such services can be made by the Department only when they are provided to a recipient who is a resident of a county or a jurisdiction that *does not* levy a special tax for the purpose of providing care for tuberculosis patients. It is the responsibility of the hospital to determine whether such tax levy funds are available to pay for these services prior to submitting a claim to the Department.

Except as specified below, inpatient services for psychiatric care and treatment are not considered to be general inpatient services and may be provided only by hospitals enrolled for category of service "21", Inpatient Hospital Services (Psychiatric), and must be provided in accordance with provisions of Topic H-220.

A hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an *emergency* basis for a maximum period of three (3) days.

Inpatient services provided for the physical rehabilitation of patients during an acute stage of a disabling illness or injury are considered to be general inpatient services. When the acute stage ends and the recipient no longer requires acute hospital care but does require comprehensive inpatient physical rehabilitation services, such services may be provided only by hospitals enrolled for category of service "22", Inpatient Hospital Services (Physical Rehabilitation), and must be provided in accordance with provisions of Topic H-230.

Inpatient services provided to a patient during an acute stage of renal disease are considered general inpatient services; however, when the services are provided for patients involved in Federal or State programs covering end-stage renal disease, they are not considered to be general services. Inpatient services for end-stage renal disease treatment may be provided only by hospitals enrolled for category of service "23", Inpatient Hospital Services (End Stage Renal Disease), and must be provided in accordance with the provisions of Topic H-240.

H-211 *Participation*

Enrollment to participate as a provider of general inpatient hospital services is accomplished as indicated in Topic H-201. There are no additional enrollment requirements to be met for the provision of this category of service.

H-212 *Notification of Hospital Admission*

(Not required at time of MMIS implementation.)

H-213 *Utilization Review*

Before a payment for an inpatient hospital stay can be considered by the Department, utilization review must be completed. Payment can be made only for those services approved by the appropriate utilization review authority.

Utilization review consists of:

1. *Admission Certification*—a review of the medical necessity for inpatient hospital admission.

2. *Continued Stay Review*—a review of the medical necessity for the length of stay as well as for the appropriateness of the level of care.

3. *Medical Care Evaluation Studies*—a medical care review in which an assessment is made of the quality and/or the nature of the utilization of health care services.

The specific Professional Standards Review Organization (PSRO) under contract with the Department of Health, Education and Welfare (HEW) to perform utilization review will perform utilization review of all inpatient hospital services provided to Public Aid recipients.

Until all hospitals have signed a Memorandum of Understanding with a PSRO, the appropriate utilization review authority will be contingent on the existence of a PSRO and the category of inpatient services provided, as specified in subsequent topics in Chapter H-200.

H-213.1 Hospitals With Signed PSRO Memorandum of Understanding

For hospitals operating under signed MOU, utilization review of all inpatient services provided to Public Aid recipients and applicants is the responsibility of the PSRO. It is the responsibility of the PSRO to inform and direct each hospital in its area regarding implementation of the utilization review program.

The PSRO must review the medical necessity of all inpatient hospital services for Public Aid recipients and applicants even though some of the services provided are not covered by the Medical Assistance Program.

H-213.2 Hospitals Without A Signed Memorandum of Understanding With A PSRO

For hospitals without a signed MOU, the Utilization Review Committee (URC) is responsible for utilization review of all inpatient services provided to Public Aid recipients, unless otherwise specified in subsequent topics in Chapter H-200.

H-213.3 Effect of Utilization Review on Payment

The maximum number of days of inpatient hospitalization for which payment can be made by the Department is the number approved by the appropriate utilization review author-

ity. Under ordinary circumstances, only days approved as medically necessary can be allowed for payment and are to be coded 01—acute: certified.

If the hospital anticipates difficulty in arranging placement at the appropriate level of long term care which will be required by a patient following hospital discharge, the Department, as the approval authority, will allow payment, *up to a maximum of three (3) days* in addition to the number of days approved as medically necessary, when the following conditions have been met. The social service department is to contact the local Public Aid office (Nursing Home Service Office in Cook County) three (3) days prior to the anticipated discharge date. If neither the social service office of the hospital nor the local Public Aid office can arrange appropriate placement, the hospital must phone the Department's Special Approval Coordinator to request prior approval of non-acute inpatient days. (See Appendix H-21 which details instructions for requesting special approval and billing procedures for approved "waiting for long term care placement" days.) These days are to be coded 03, 04, or 05, as applicable.

In situations where patients from group care facilities require acute care and a bed is held by the group care facility, no consideration can be given to payment beyond the days approved as medically necessary.

Regardless of the number of days approved by a utilization review authority, payment will not be made by the Department for (1) services that are not covered in the Medical Assistance Program or (2) services that the hospital is not enrolled with the Department to provide. For example:

> Even though a utilization review authority approves a hospitalization for cosmetic surgery, payment will not be made for the hospitalization as it is not a covered service. (See Topic H-204.)

The utilization review authority might approve a hospitalization for end-stage renal disease services even though the hospital is not enrolled with the Department for the provision of this category of service. In such a situation, payment will not be made by the Department.

H-214 *Charges*

Charges are to be made for inpatient hospital services based on calendar days. The day of discharge is not counted. An admission with discharge on the same day is counted as one day. If a recipient is admitted; discharged and re-admitted on the same day, only one day is counted.

The day on which a recipient begins a leave of absence must be treated as the day of discharge or non-certified day and cannot be counted as a covered day unless the patient returns to the hospital prior to midnight of the same day.

The total number of days for which charges can be made cannot exceed the number approved by the appropriate utilization review authority, except as specified in Topic H-213.3.

H-214.1 Recipient With No Medicare Coverage

For recipients who are not eligible for either Medicare Part A or Part B benefits, charges are to be made at the inpatient per diem rate approved by the Department for the hospital.

H-214.11 *Services of Hospital Based Physicians*

If a physician's salary is included in the hospital's cost report for direct patient care, the physician may not bill on a fee-for-service basis.

H-214.12 *Blood Transfusion*

When blood transfusions or packed red cells are administered, hospitals are to encourage replacement of blood used. Any blood replacement must be shown as a credit on a pint-for-pint basis on billings to the Department.

H-214.13 *Services to Newborn Children*

In obstetrical cases, charges associated with delivery and routine newborn nursery care are considered to be incurred by the mother; therefore, only one per diem charge is to be made, in the mother's name, to cover services to both the mother and the newborn child. In instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery (such as in a prenatal center), additional charges may be submitted on a separate inpatient invoice in the child's name; if the child has been determined eligible for assistance.

To expedite application and determination of a newborn child's eligibility for assistance, hospitals may maintain a supply of Form DPA 243, Request for Assistance for Additional Family Member, and provide this form to expectant recipients at the time of admission. (See Appendix H-9 for a facsimile of Form DPA 243.)

H-214.14 *Services Related to Sterilization*

Hysterectomy Performed During Hospital Stay

No payment will be made for a hospital stay when a hysterectomy is performed solely for the purpose of rendering an individual permanently incapable of reproducing, or where, if there is more than one purpose to the procedure, the hysterectomy would not be performed but for the purpose of rendering the individual permanently incapable of reproducing.

Payment for a hospital stay will be made when the stay includes the performance of a medically necessary hysterectomy, which was not performed for the purpose of rendering the woman incapable of reproducing. Payment will be made only if the person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing; and the individual has signed Form DPA 1977, Acknowledgement of Receipt of Hysterectomy Information.

Appendix H-10a is a copy of Form DPA 1977. In order to insure that requirements have been met, the physician who obtained the signed Form DPA 1977, must provide the hospital with a copy for viewing by hospital staff and subsequent attachment to the Form DPA 117 which indicates a hysterectomy was performed.

Sterilization Procedures Other Than A Hysterectomy

Hospital charges for an inpatient stay may be made for services associated with a sterilization procedure, other than a hysterectomy, only when the following standards have been met:

1) the individual has voluntarily given informed consent in accordance with the requirements of the Federal regulations (see "Informed Consent" this topic),

2) the individual is at least 21 years old at the time consent is obtained,

3) the individual is not institutionalized or mentally incompetent, and

4) at least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she have given informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Informed Consent

An individual has given informed consent only if:

1) The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information or advice to the individual to be sterilized:

a) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.

b) A description of available alternative methods of family planning and birth control.

c) Advice that the sterilization procedure is considered to be irreversible.

d) A thorough explanation of the specific sterilization procedure to be performed.

e) A full description of the discomforts and risks that may accompany or follow the performing of that procedure, including an explanation of the type and possible effects of any anesthetic to be used.

f) A full description of the benefits or advantages that may be expected as a result of the sterilization.

g) Advice that the sterilization will not be performed for at least 30 days except in cases of premature deliveries or emergency abdominal surgery as indicated above.

2) Suitable arrangements were made to insure that the information specified in (1)(a) through (g) was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

3) An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;

4) The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

5) The consent form requirements specified below were met; and

6) Any additional requirements of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

Informed consent may not be obtained while the individual to be sterilized is:

1) In labor or childbirth;

2) Seeking to obtain or obtaining an abortion; or

3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

In order to insure that consent requirements have been met, the physician who obtained consent for the sterilization must provide the hospital with a copy of the properly completed Form DPA 2189, Consent Form, (R-1-79) for viewing by hospital staff and subsequent attachment to the hospital bill. (Appendix H-11a is a facsimile of Form DPA 2189, Consent Form.)

H-214.15 *Services Related to Termination of Pregnancy*

Charges for an abortion and the associated hospital services are covered services in the Medical Assistance Program only when;

1) The abortion is performed prior to fetal viability and a licensed physician in Illinois certifies in writing that the procedure is "medically necessary". A "medically necessary" abortion is an abortion which is necessary for the preservation of the life or the physical or mental health of a woman seeking such treatment, in the professional judgment of a licensed physician in Illinois, exercised in

light of all factors relevant to her health. "Fetal viability" means the point during pregnancy at which, in the professional judgment of a licensed physician in Illinois, a fetus is potentially able to live outside the mother's womb, albeit with artificial aid, such that there is a potentiality for meaningful life, not merely momentary survival; OR,

2) The abortion is perfomed prior to or after fetal viability, and it is certified in writing:

a. by a licensed physician in Illinois, that (s)he has determined that the life of the mother would be endangered if the fetus were carried to term, OR,

b. by two licensed physicians in Illinois, that they have determined that severe and long-lasting physical health damage to the mother would result if the fetus were carried to term; OR,

c. that the abortion is necessary for a victim of rape or incest, when the rape or incest was reported promptly to a law enforcement agency or public health service. (A pregnant woman under 18 is considered to have been the victim of rape, even if she was not forced to have sexual relations.) Note that the required report must be made within 60 days of the incident and must show the name and address of the victim and the date of the incident.. It also must show the name, address and signature of the person making the report and the date of the report.

Excerpts from, B. NATHANSON, ABORTING AMERICA (1979)*

CH. 16
"DEEPER INTO ABORTION"

The news of the Supreme Court's abortion decisions broke on the same January day of 1973 as did word of Lyndon Johnson's death. Curiously, of the two events, I was more interested in ruminating about the former President. I have always been interested in political history, and to me he was a mysterious figure. How could such a consummate politician have allowed himself to get trapped in the Viet Nam quagmire? Of course, I was pleased with Justice Harry Blackmun's abortion decisions, which were an unbelievably sweeping triumph for our cause, far broader than our 1970 victory in New York or the advances since then. I was pleased with Blackmun's *conclusions,* that is. I could not plumb the ethical or medical reasoning that had produced the conclusions. Our final victory had been propped up on a misreading of obstetrics, gynecology, and embryology, and that's a dangerous way to win. But as Vince Lombardi said, "Winning isn't everything—it's the *only* thing."

My relative disinterest in the abortion rulings is explained by the fact that on the day after New Year's of 1973 I plunged into a new phase of my career, as the Chief of Obstetrical Service at Woman's Hospital, St. Luke's Hospital Center, one of the best equipped and busiest departments in Manhattan. I had left the abortion clinic in a state of exhaustion and had just resigned the gynecology directorship at the Hospital for Joint Diseases, planning to avoid any more large projects or administrative positions. But upon my return from the family vacation

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in Europe, Harold Tovell, the director of the over-all obstetrics-gynecology department, asked me to assume the position at Woman's, and I felt that I simply had to do this, as something of a balance to the medical work I had performed previously. The four years in that post were to have a critical impact upon my thinking about abortion.

One of the first things I did in 1973 was to supervise the establishment of a sophisticated perinatology unit at Woman's, with Tovell laboring valiantly to raise needed funds for fetal electronic heart monitoring machines and other expensive equipment. On of the great underreported medical revolutions of our time is this field of perinatology, the intensive investigation and treatment not only of the newborn baby but of the fetus, this enigmatic organism that, only months before, my charges at the abortion clinic had been extinguishing on a record scale. Oddly, there has been an explosion of knowledge about the fetus during the very years that mass abortion developed.

Over the past fifteen years or so, the pendulum in obstetrics has swung sharply from almost-exclusive concern with the life of the mother (the orientation in which I was trained in my residency) toward strong interest in the health of the fetus. Not that the life of the mother is held in any lower regard, but with the advances in antibiotics, anesthesia technique, and the like, maternal mortality has dropped to an almost irreducible minimum. In many large medical centers the leading causes of maternal death are no longer the old bogeymen of hypertensive disorders, infection, and hemorrhage, but rather cancer or heart disease that coincide with pregnancy, and thrombo-embolic disease. So work on the fetus is the obvious direction for future research. Three English-language journals for this specialization all began publication in 1976: ***Monographs in Fetal Physiology, Reviews in Perinatal Medicine,*** and the best-known,

Perinatal Medicine. In 1977 the citations on biological studies of the fetus consumed more than fifty-one columns of want-ad-size type in the *Index Medicus,* which works out to about 2,000 research articles.

A layman looking at abortion fixes upon the bloodied amorphous remains lying in the gauze bag inside the suction bottle; Right-to-Lifers constantly play upon this squeamishness. No physician, however, could do his work if the sight of human tissue and blood bothered him. Once the operation proceeds, the remains are just tissue to be dispatched to the pathology lab. No, the issue is not the existence of the tissue, but the prior decision that the operation is proper. What began to erode the N.A.R.A.L. dogmas was the daily realization of the "intrauterine patient" that we were treating, tracing, sampling, and observing through electric monitoring or the flickering images on an ultrasonic screen. To a physician, *that* is reality.

This evolution of my thinking will sound incredible to many. I was generally aware of these biological developments during the years of my abortion crusade. Three things happened. First, I reflected again on the older knowledge in perinatology. Second, new data were reported all the time. Third, and most important, I opened myself up to the data. When one is caught up in revolutionary fervor, one simply does not want to hear the other side and filters out evidence without realizing it. Until 1973 I was sold a bill of goods. No—let me be honest—I was selling a bill of goods. I had been terribly disturbed by the injustice and hypocrisy of the '60s, the disparity between rich and poor, East Side and West Side. I had seen the victims of self-abortion and hack abortionists. After the fever of activity had cooled, I found myself reflecting on the seeds of our revolution.

Besides the work at Woman's Hospital, I was influenced by some past reading I had done, and in particular an intriguing novel, *You Shall Know Them,* by the French author Vercors (pseudonym for Jean Bruller). The English translation came

out in 1953 and a copy fell into my hands around 1968. I felt uneasy every time my mind strayed back to this intriguing novel.

Vercors spins a tale about an expedition of anthropologists who visit an island near Australia and stumble across a surviving "missing link" tribe, well hidden in the jungles, that displays some attributes of man and some of beast. To press the issue of whether the creatures, nicknamed "tropis," are human, a journalist on the expedition named Douglas Templemore decides to artificially inseminate a female tropi with his seed. Back in England, Templemore then slays his offspring intentionally, to force a murder trial and settle the question of defining "humanity." On that question rests, among other things, the scheme of an Australian industrialist to train tropis for slave labor in his textile mills. If they are not humans, what differences does it make? An Act of Parliament offers this definition: "Man is distinguished from the Beast by his spirit of religion." This sets up possibilities for satire which Vercors exploits deftly. What haunted me was the point raised by Templemore's lawyer in his summation at the murder trial:

"It did not rest with the tropis to be or not to be members of the human community, but with us to admit them to it. . . . No one is a human being by a right of nature but, on the contrary, before being recognized as such by his fellow man, he must have undergone—in a manner of speaking—an examination, an initiation." Should not the fetus, too, be examined to determine whether it is a member of the human community? Or, equally important, to determine whether it is *not* a member of the human community, and if not, *why* not?

When I cleared out my desk at CRASH on August 26, 1972, before departing for my much-needed vacation, I carefully packed up and removed all my files. I had determined to write up my experience, which I felt was too important to vanish without careful analysis, though I had no idea what I

would write. That summer, Hunter Frost arrived on the scene. He was an old friend who had been amazingly successful in New York advertising. While his star was almost at its zenith he had quit his agency, gone back to New York University to get a master's degree in English, and moved his family to Colorado to teach at a prestigious prep school, the Fountain Valley School. Hunter was a thin, intense man with a most engaging manner, and I had always been able to confide in him, perhaps more so than with anyone else I knew.

We began to talk about abortion. I took him to the clinic on several occasions till he got to know everyone, and he interviewed numbers of people with an eye to doing a book on the history and functioning of CRASH. But Pyle and I were barely speaking by then, and without her cooperation he felt it would be too difficult to do the book. Instead, we spent long hot evenings discussing my troubled feelings about abortion. It was the first time I had really opened up my own thoughts and discussed the issue in depth with anyone. I tried to sort out my ideas, to formulate some moral posture on the entire subject. We drafted a few statements, diagrams, and declarations, but in the end I knew that something was lacking. Through those ventilating sessions with Hunter it became increasingly clear that I—Bernard Nathanson, a founding father of N.A.R.A.L. and operator of the largest abortion clinic in the world—was entertaining serious doubts now about abortion. The realization was a bit frightening. The mental landscape was incomplete. I knew that I had to bring to the matter something more profound than a formless, splanchnic aversion. Hunter returned to Colorado in late August only half-humorously suggesting that I was suffering some undiagnosable equivalent of the *crise de foie,* only the target organ was not the liver but something in the region of the conscience. We had set some things to paper, but only the black. The white had yet to be formulated. 'Chiaroscuro" was then the working title of my nascent article.

Were those germinating seeds of doubt evident to my clinic staff and board, to the abortion activists? At the annual N.A.R.A.L. meeting that fall some were too polite to ask about my resignation from the clinic, evidently aware that it was a touchy subject with me, like a nasty divorce. To those who inquired, my stock answer was that I had exhausted myself. I told them of my desire to return to the comparative serenity of private practice. In addition, my group of junior associates had broken up that summer, so I was alone in my practice and no longer had partners to cover for me while I was engaged in other areas.

During the spring of 1973 I began reformulating my article, newly influenced by perinatology. I had by then decided two things: first, that we had to continue offering abortions without restriction, and second, that everyone ought to be counseled to think about abortion more carefully. That following summer Hunter Frost visited again, and we spent long hours batting arguments back and forth as he helped me with the phrasing of the evolving article. When the piece was completed I sent a copy to Larry Lader at N.A.R.A.L. He made no objections, but asked me to hold it a couple of months because "the climate is not right." Translated, that meant that once again there was some sort of intramural fight within N.A.R.A.L. At summer's end I submitted my manuscript to the *New England Journal of Medicine,* in which I had reported on our clinic's safety record with the first 26,000 patients. The editor, Franz J. Ingelfinger, took the unusual step of phoning me to accept the piece for publication as soon as possible. He asked me to add an introductory section, and the article appeared as follows in the "Sounding Board" section of the November 28, 1974, issue:

Deeper into Abortion

In early 1969 I and a group of equally concerned and indignant citizens who had been outspoken on the subject of legalized abortion organized a political action unit

known as NARAL—then standing for National Association for Repeal of Abortion Laws, now known as the National Abortion Rights Action League. We were outspokenly militant on this matter and enlisted the women's movement and the Protestant clergy into our ranks. We used every device available to political-action groups such as pamphleteering, public demonstrations, exploitation of the media, and lobbying in the appropriate legislative chambers. In late 1969 we mounted a demonstration outside one of the major university hospitals in New York City that had refused to perform even therapeutic abortions. My wife was on that picket line, and my three-year-old son proudly carried a placard urging legalized abortion for all. Largely as a result of the efforts of this and a few similar groups, the monumental New York State Abortion Statute of 1970 was passed and signed into law by Governor Nelson Rockefeller. Our next goal was to assure ourselves that low cost, safe, and humane abortions were available to all, and to that end we established the Center for Reproductive and Sexual Health, which was the first —and largest—abortion clinic in the Western world. Its record was detailed in these pages in February 1972.

Some time ago—after a tenure of a year and a half—I resigned as director of the Center for Reproductive and Sexual Health. The Center had performed 60,000 abortions with no maternal deaths—an outstanding record of which we are proud. However, I am deeply troubled by my own increasing certainty that I had in fact presided over 60,000 deaths.

There is no longer serious doubt in my mind that human life exists within the womb from the very onset of pregnancy, despite the fact that the nature of the intrauterine life has been the subject of considerable dispute in the past. Electrocardiographic evidence of heart function has been established in embryos as early as six weeks. Electroencephalographic recordings of human brain activity have been noted in embryos at eight weeks. Our capacity to measure signs of life is daily becoming more sophisticated, and as time goes by, we will doubtless be able to isolate life signs at earlier and earlier stages in fetal development.

The Harvard Criteria for the pronouncement of death assert that if the subject is unresponsive to external stimuli (e.g., pain), if the deep reflexes are absent, if there are no spontaneous movements or respiratory efforts, if the electroencephalogram reveals no activity of the brain, one may conclude that the patient is dead. If any or all of these criteria are absent—and the fetus does respond to pain, makes respiratory efforts, moves spontaneously, and has electroencephalographic activity—life must be present.

To those who cry that nothing can be human life that cannot exist independently, I ask if the patient totally dependent for his life on treatments by the artificial kidney twice weekly is alive? Is the person with chronic cardiac disease, solely dependent for his life on the tiny batteries on his pacemaker, alive? Would my life be safe in this city without my eyeglasses?

Life is an interdependent phenomenon for us all. It is a continuous spectrum that begins in utero and ends at death—the bans of the spectrum are designated by words such as fetus, infant, child, adolescent, and adult.

We must courageously face the fact—finally—that human life of a special order is being taken. And since the vast majority of pregnancies are carried successfully to term, abortion must be seen as the interruption of a process that would otherwise have produced a citizen of the world. Denial of this reality is the crassest kind of moral evasiveness.

The fierce militants of the Woman's Liberation evade this issue and assert that the woman's right to bear or not to bear children is her absolute right. On the other hand the ferocious Right-to-Life legions proclaim no rights for the woman and absolute rights for the fetus.

But these "rights" that are held to be so obvious and so undeniable are highly suspect. None of us have "rights" that go beyond the inter-related life that is our common heritage on this planet. Our "rights" exist only because others around us care enough about us to see to it that we have them. They have no other source. They result from no other cause.

Somewhere in the vast philosophic plateau between the two implacably opposed camps—past the slogans, past the pamphlets, past even the demonstrations and the legislative threats—lies the infinitely agonizing truth. We are taking life, and the deliberate taking of life, even of a special order and under special circumstances, is an inexpressibly serious matter.

Somehow, we must not deny the pervasive sense of loss that should accompany abortion and its most unfortunate interruption of life. We must not coarsen our sensitivities through common practice and brute denial.

I offer no panacea. Certainly, the medical profession itself cannot shoulder the burden of this matter. The phrase "between a woman and her physician" is an empty one since the physician is only the instrument of her decision, and has no special knowledge of the moral dilemma or the ethical agony involved in the decision. Furthermore, there are seldom any purely medical indications for abortion. The decision is the most serious responsibility a woman can experience in her lifetime, and at present it is hers alone.

Can there be no help for the pregnant woman bearing the incalculable weight of this moral tension? Perhaps we could make available to her—though it should by no means be mandatory—a consultative body of unique design, much like Saint-Simon's Council of Newton. To meet the new moral challenges of the abortion decision, we may very well need specialists, some of new kinds, to serve on such a body—a psychohistorian, a human ecologist, a medical philosopher, an urbanologist-clergyman. The counseling that such a body could offer a pregnant woman would be designed to bring the whole sweep of human experience to bear on the decision—not just the narrow partisanship of committed young women who have had abortions and who typically staff the counselor ranks of hospitals and clinics now.

My concern is increased by the fact that the sloganeers, with their righteous pontifications and their undisguised desires to assert power over others, have polarized American reactions into dimly understood but tenaciously held positions. The din that has arisen in our land has already created an atmosphere in which it is difficult, if not impossible, for the individual to see the issues clearly and to reach an understanding free from the taint of the last shibboleth that was screamed in her ear.

Our sense of values has always placed the greatest importance upon the value of life itself. With a completely permissive legal climate for abortion (and I believe that we must have such a climate—that abortion must be unregulated by law) there is a danger that society will lose a certain moral tension that has been a vital part of its fabric. In pursuing a course of unlimited and uncontrolled abortion over future years, we must not permit ourselves to sink to a debased level of utilitarian semiconsciousness.

I plead for an honest, clear-eyed consideration of the abortion dilemma—an end to blind polarity. We have had

enough screaming placards and mindless marches. The issue is human life, and it deserves the reverent stillness and ineffably grave thought appropriate to it.

We must work together to create a moral climate rich enough to provide for abortion, but sensitive enough to life to accommodate a profound sense of loss.

* * * * *

During the years after "Deeper," I continued to ponder it all. It was apparent that the public issue was not going to die. Justice Blackmun had inflamed it with his decisions rather than putting it to rest. All we had were the coathanger pins of the pro-choicers and the roses and bottled fetuses of the pro-lifers. Where was the argumentation from a religiously neutral, biologically informed viewpoint? Medical ignorance on the subject abounded, and I had had an enormous mass of clinical experience of perhaps 75,000 abortions, including ones I had supervised at the clinic, had indirect hospital knowledge of, or had performed myself. I decided that I must start over from the beginning, compile and examine all my life experiences and all the pros and cons in the debate, and offer my conclusions, going deeper yet into abortion.

CH. 24

A LIFE FOR A LIFE

In morality, life can only be equated with life, not with convenience or sociology or politics or economics or poverty; not even (in the truly hard cases) with the burden of responsibility for a seriously retarded or handicapped child, or of bearing a child resulting from rape or infidelity. In arguing an issue of life, one can only invoke issues of life to counterbalance it. Liberals who are pro-abortion immediately recognize that, in capital punishment, only murder would justify even *considering* the intentional taking of life. We do not execute car thieves.

Those of us in the pro-abortion crusade used two special "mother's life" arguments. The first was the "coathanger" plea. Not only is this a self-inflicted threat to life, but it is one that, as I have stated, would be reduced to the vanishing point by recent medical developments if abortion were again made illegal.

The other case we cited was the threat that if a particular woman were not allowed to abort, she would kill herself. In our rush to get hospital permissions, as I have recounted, many psychiatrists were willing to enlarge upon such dangers, but the clinical fact is that suicide virtually never results from pregnancy in and of itself. If pregnant women commit suicide, it is because of issues other than the pregnancy. As it happens, pregnant women kill themselves noticeably less often than do non-pregnant women. It may even be that pregnancy is a protection *against* suicide. A former New York City medical examiner once stated that he had never in his career seen a single case of a pregnant woman who took her own life. Even the brief of pro-abortion plaintiffs in the federal *McRae* v. *Califano* case admits, "Not one of the maternal mortality studies lists a single case of maternal death from suicide."

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The abortion policy that I have finally settled upon distinguishes between medical abortions (permissible) and those that are not medically indicated (not permissible). We must, in applying this principle, reject the sloppy usage of "medical indications" that I was a party to in the 60's covering all manner of psychiatric, social, or eugenic perplexities, or simply the wish of the mother. On the other hand, it must be more flexible and medically sophisticated than anything that I have seen emanating from the Right-to-Life forces. The list of indications *cannot be etched in stone;* it varies by medical knowledge. There was a time when tuberculosis was correctly considered to be an indication; now it is not. On the other hand, medical research has identified indications that formerly

were unknown. Some specific indications might apply with one pregnancy and not with another.

As a point of departure, let us take the so-called "Hyde Amendment" as it was reshaped and finally passed by the U.S. Congress in December 1977. This law had to do only with what cases should come under Medicaid poverty funding, but in effect it expressed what the people's representatives considered to be generally acceptable grounds for abortion. One clause covered promptly reported rape and incest (not a medical indication), and the rest of the bill specified those cases:

1. ". . . where the life of the mother would be endangered if the fetus were carried to term." (The lethal ectopic pregnancy is listed in a separate section.)

2. ". . . where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term," as determined by two physicians.

As a member of the American College of Legal Medicine, I have some familiarity with the ways in which legal language must accommodate medical imponderables, and I must state that Congress here was off the mark, as the Supreme Court had been previously. First, the wording is unacceptable vague. To what *extent* must life be endangered? The danger should be compared with the statistical average in routine, uncomplicated pregnancy, since there is a theoretical statistical risk in *any* pregnancy (or, for that matter, in any auto trip). The current rule of thumb is that fewer than twenty of 100,000 pregnant women will die. This figure should not be fixed by statute since it will continue to decline, but the law should state that the latest data of biostatisticians be used to define which medical problems produce a demonstrable increment of death. To me, a statistically significant increment over the usual risk of pregnancy constitutes an endangerment of life that justifies abortion. And it must be the pregnancy itself that materially

contributes to the condition; abortion makes no sense in an endangered woman if the elimination of alpha has no bearing on her prospects.

What constitutes "severe and long-lasting" health damage short of imminent danger to death? This is not medically precise. Most health conditions that are cited by pro-abortionists are temporary and can be treated. There must, rather, be a reasonable probability that the co-existence of pregnancy will materially and significantly shorten the mother's life-span. This rule cannot be quantified, but it is not difficult to determine medically in a particular case. Again, the pregnancy itself must be determined to be the cause of the life-shortening.

So I am proposing two "life" criteria: pregnancy that raises the risk of imminent death *now*, and pregnancy that will hasten death *then*. My proposal would radically reduce the number of legal abortions to perhaps several thousand a year. Even under the fuzzy Hyde language, between February 14 and December 31, 1978, there was a reported 99 per cent decrease nationally in Medicaid-funded abortions from a previous total of about 250,000 per year. Only 385 were approved on health danger, 1,857 for life endangerment, and 61 for rape/incest. This shows the degree to which abortions are being performed on other than medical grounds. In practice, it is not possible to spell out every probable element in medical practice, and each case of a particular disease will vary. What we need—and can develop—is a workable ethical standard.

Each mother must be considered individually. Some might suppose that because the death rate of women in pregnancy is statistically higher after age thirty-five or age forty, age alone would justify abortion under my proposal. This is a misunderstanding. It is the specific medical problems such as those to be discussed below that increase with age and that kill the women, not the age as such. Doctors treat patients and diseases, not age groups. Sometimes the very young teen-age mother is set apart

into a high-risk category, but this is a social problem rather than a strictly medical one. The statistically higher rate of difficult pregnancy is not due to the very young mothers' age, but to the fact that they do not consult physicians readily or often enough.

My policy would exclude a variety of maladies in pregnancy that some doctors have cited as "medical indications," but which are treatable and not life-endangering: varicose veins, myoma (benign tumor of the uterus), urinary tract infections, an expected necessity for Caesarean section, anemia and other forms of malnutrition, hyperemesis (excessive vomiting), peptic ulcer, or cystitis. In cases of multiple sclerosis, the symptoms are exaggerated in pregnancy, but life is not shortened as such. In the "possible" category—justifiable with certain patients—might be colitis, respiratory maladies such as bronchectasis, and some chronic degenerative diseases of the nervous system.

Some other typical indications:

1. *Diabetes*—This disease is life-threatening and carries other health hazards, and it usually worsens in late pregnancy. But there is no firm evidence that pregnancy in and of itself shortens the diabetic mother's life-span, so it probably is not an indication. Diabetes *is* a very difficult problem for alpha, which raises the eugenic issue. At the parents' option, this may require birth control or sterilization.

2. *Obesity*—Using the guideline of 250 pounds (some obstetricians say 300), this condition produces a higher mortality rate in pregnancy because it is difficult to treat the patient, delivery is more problematic, and other medical problems result. The increased threat may be such that abortion would have to be considered.

3. *Cancer*—(Other than removal of a cancerous uterus, which even the Vatican accepts.) It is often stated that cancer is a medical indication. Cancers other than

those of the breast and the female genital tract are probably not affected by pregnancy. Even in these cases, cancer is not necessarily an indication, since certain cases are not worsened by pregnancy. In breast cancer, the danger often can be determined through a new test for whether the cancer is estrogen-receptor positive. If it is, pregnancy probably will inflame the condition and may be lethal; abortion is justified.

4. *Chronic heart or kidney disease*—Unlike with diabetes, here there is a direct link between the pregnancy and the increased strain that is put on the diseased heart or kidneys, so both are medical indications. A Right-to-Life advocate might argue that there are options: One could perform open-heart surgery or a kidney transplant, or use kidney dialysis, and avoid the need to abort. In my view, these remedies must not be required because the mortality rate of the corrective procedure is noticeably higher than that of the abortion, most certainly with surgery and possibly with dialysis. On the other hand, I would reject the case where a mother can cope while resting during pregnancy but endangers her heart if she does housework. In this case, housekeeping help should be provided, not an abortion.

5. *Sickle-cell anemia*—(As opposed to common anemia.) The rare S-C form of sickle-cell may be lethal in pregnancy but even the common S-S form is risky; either is an indication.

6. *Intrauterine device*—The IUD is, of course, supposed to prevent pregnancy, but in certain cases the woman becomes pregnant anyway with the device still present in the womb. It must be removed as soon as pregnancy is diagnosed. However, if by mistake the IUD is left in until pregnancy has so advanced that it cannot be removed, there is no question that abortion is always

permissible. Even though some IUD pregnancies would produce healthy children without incident, the obstetrician never knows which cases. An infection that an IUD might produce if left in the uterus is so deadly and spreads so rapidly that the device is a continual threat to the mother's life.

7. *Hypertension*—Elevated blood pressure by itself is occasionally a threat to life. About one in three hypertensive pregnant women also will develop pre-eclampsia or its advanced state, eclampsia, later on in the pregnancy. (Pre-eclampsia is a syndrome with constricted small arteries, particularly in the uterus, eyes, liver, and brain, the latter possibly producing a stroke. Eclampsia is an advanced state of the syndrome, with convulsions. We do not know the cause of this disease and therapy is difficult.) Pending better predictability of which cases of hypertension will lead to pre-eclampsia/eclampsia, or improved therapy for this disease, advanced hypertensive disease should be grounds for abortion.

8. *Thrombo-embolic disease*—A woman may have a blood clot or an embolism (a clot that breaks off from its site) and recover from the disease, but if pregnancy later occurs there is a much higher risk of a rapid and lethal clot. Thus, this may be an indication. Superficial phlebitis (inflammation of a small surface vein) is not an indication, but deep-vein phlebitis is quite dangerous. Fortunately, this is a case where drug treatment is feasible and abortion is not necessary. The physician is able to prescribe heparin, a drug that does not cross the placenta and therefore does not endanger alpha, either.

This is an incomplete list of the major examples, assuredly not an exhaustive catalogue, but it should serve to illustrate how the above principles would apply.

Along with these proposals, I would like to propose that the anti-abortion legions declare a moratorium on their marches at hospitals and clinics and their intimidation of women patients long enough to ponder these questions that obstetricians face daily and to notify the rest of us which abortion indications *they* are willing to endorse.

Back in January of 1975 when Ruth Proskauer Smith was deciding whether I should be excommunicated from N.A.R.A.L., she sent me an inquisition-by-mail. One of her seven questions demanded of me, "Does your expressed anguish at having 'presided over 60,000 deaths' imply that you plan to make changes in your own medical practice?"

The answer in 1975 was that it made not the slightest difference. I was willing to perform an abortion for any patient, at any stage prior to "viability," for any reason. I considered the physician to be merely the instrument of the woman's desires in the matter of abortion.

Given the rather strict list of abortion justifications that I have just presented, the reader of this book will likely be asking Ruth Smith's question all over again. Do I (medically) practice what I preach?

About a year after resigning from N.A.R.A.L., I started feeling viscerally that I did not like doing abortions. Still, I did them. Sometime toward the end of 1976 this changed. One day, I cannot now recall the patient or the circumstances, I decided that I would perform no more of the grotesque "second trimester" abortions except on strict medical grounds—even for longtime patients in my private practice. Around the same time I also began refusing to do elective abortions at *any* stage for new patients who came to me. I would tell them, "I'm sorry, I don't do abortions any more, for ethical reasons, but my associate Dr.———— will do it for you. I will be on hand in the operating room during the procedure." And so quietly, without fanfare or notice, I was out of the elective (i.e., non-medical)

abortion business, except for "first-trimester" abortions done for established patients of mine.

My phased withdrawal went ahead in December of 1977, while I was doing the preliminary reflections toward this book. For the first time, I refused to do an early abortion for a longtime patient, citing the same ethical objections that I routinely used with new patients. She was not at all happy at this news and wanted me to perform it anyway. Quietly, I checked out my legal situation with my lawyer, regarding the question of "medical abandonment" of a patient. The lawyer advised me that this was a new legal issue, particularly because I had not changed my views as a result of religious conversion, but that there was little risk. He said I should be on acceptable legal footing if I referred her to an obstetrician-gynecologist of equal competence. In January 1978 I went ahead with the abortion anyway. She was still insistent and my own thinking had not crystallized.

During 1978 I continued refusing to do non-medical abortions for all patients, but ended up performing several anyway. In one case, I did not even raise the problem and, in fact, shielded my reluctance because, in my best judgment, the patient was unusually dependent upon me and I knew my refusal would have been interpreted as a rejection of her, probably throwing her into panic. Obstetrics and gynecology is so sensitive a field that it is probably the closest specialty there is to psychiatry. A doctor bears a heavy ethical burden in the case of a patient with an unusual degree of dependence upon him.

And so as this book went to the publishers I was caught in the paradox of considering elective abortion to be an unjust taking of human life and yet performing one now and then when I was unable to avoid it. Perhaps in the future I will refuse regardless of the circumstances.

There are 75,000 abortions in my past medical career, those performed under my administration or that I supervised in a teaching capacity, and the 1,500 that I have performed myself. The vast majority of these fell short of my present standard that only a mother's life, interpreted with appropriate medical sophistication, can justify destroying the life of this being in inner space which is becoming better known to us with each passing year. I now regret this loss of life. I thought the abortions were right at the time; revolutionary ethics are often unrecognizable at some future, more serene date. The errors of history are not recoverable, the lives cannot be retrieved. One can only pledge to adhere to an ethical course in the future.